Employee Benefit Plan for the State of Montana and Montana University System; and the Children's Health Insurance Plan (CHIP)

Medical Claims and Pharmacy Claims Payment Audit

January 1, 2002 – December 31, 2003

04C-07

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena MT 59620-1705

STATE OF MONTANA,
MONTANA UNIVERSITY SYSTEM and
CHILDREN'S HEALTH INSURANCE PLAN

ANALYSIS AND EVALUATION OF
CLAIMS PROCESSING
FOR THE PERIOD
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

ADMINISTERED BY

BLUE CROSS BLUE SHIELD OF MONTANA

FINAL REPORT

DECEMBER, 2004

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
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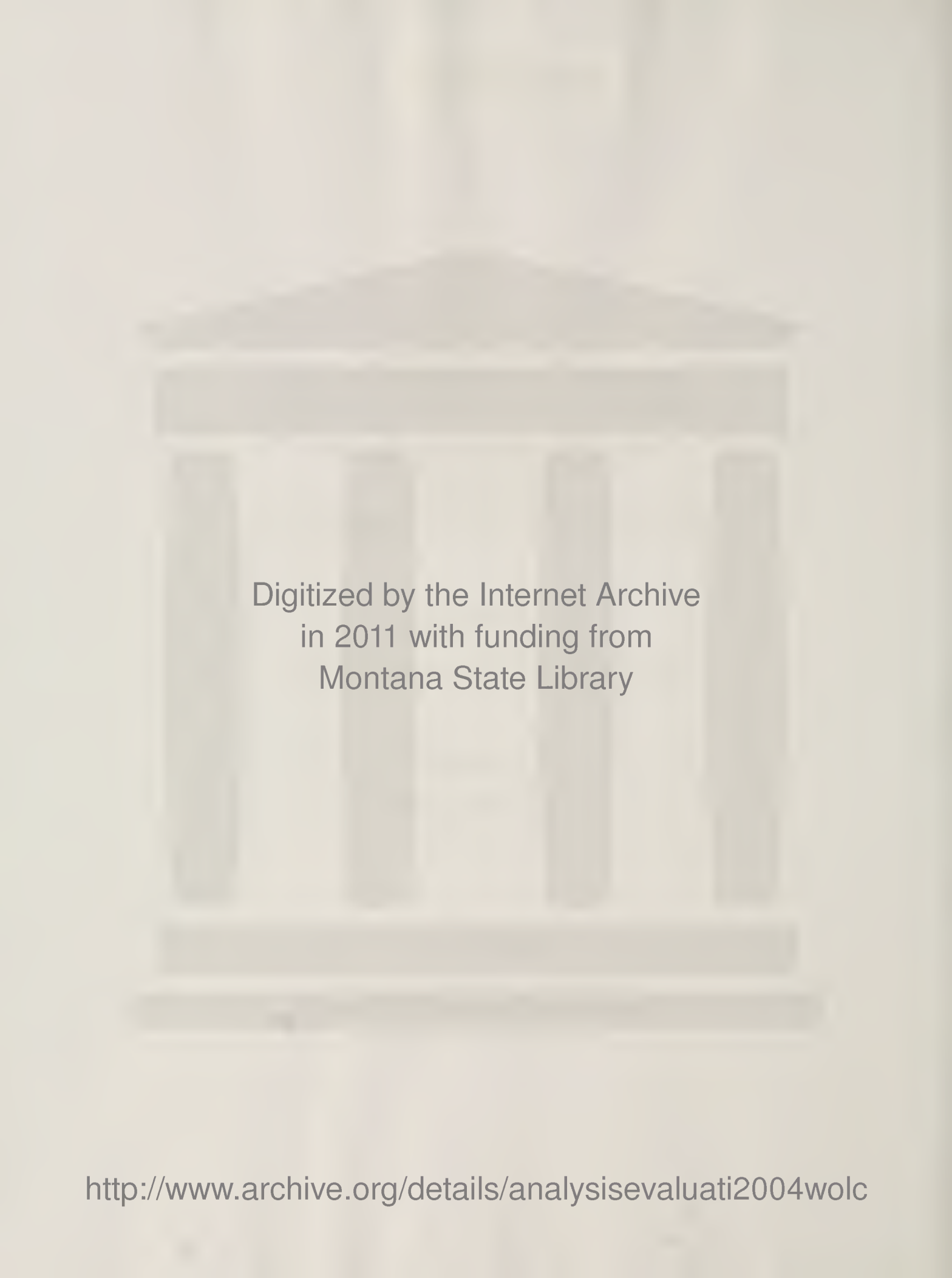

STATE OF MONTANA, MONTANA UNIVERSITY SYSTEM AND CHILDREN'S HEALTH INSURANCE PLAN
HEALTH CARE PLAN AUDIT
OF BLUE CROSS BLUE SHIELD OF MONTANA
JANUARY 1, 2002 - DECEMBER 31, 2003

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EXHIBITS

LEGISLATIVE AUDIT DIVISION

Scott A. Seacat, Legislative Auditor
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Deputy Legislative Auditors:
Jim Pellegrini, Performance Audit
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James Gillett, Financial-Compliance Audit

December 2004

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the medical and pharmacy claims for the employee benefits plans at the State of Montana, the Montana University System, and the Children's Health Insurance Plan (CHIP) Program for the two years ended December 31, 2003.

The audit was conducted by Wolcott & Associates under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of the audit report.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

04C-07

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I - INTRODUCTION

The State of Montana (State) provides self-funded medical care and dental care benefits as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered lives.

The State has negotiated a contract with Blue Cross Blue Shield of Montana (BCBSMT) to provide administration services to its indemnity medical and dental plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and has also contracted to have their medical and dental care benefits administered by BCBSMT. The plan covers approximately 5,000 employees and retirees, plus their dependents.

The Children's Health Insurance Plan (CHIP) is administered by the Department of Public Health and Human Services (DPHHS), and provides a fully insured medical care and prescription drug plan to qualifying children in the State of Montana. The plan covers approximately 11,000 children.

The State invited MUS and CHIP to participate in an audit of BCBSMT's processing of medical care and dental care claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that we were awarded the audit contract on June 21, 2004. All preliminary work was completed and the entrance meeting was held in Helena on September 8, 2004. On-site work at the State, MUS, CHIP and BCBSMT was performed during the weeks of September 7 and 13, 2004.

On-site audit services were performed at:

State of Montana
State Personnel Division
Mitchell Building
Helena, Montana 59620

Montana University System
2500 Broadway
Helena, Montana 59620

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Cathy McKittrick	Auditor	Yes
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care and dental care benefit claims paid by BCBSMT during the period from January 1, 2002 through December 31, 2003. Test work was performed on 633 previously processed claims, all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and

computation of deductible and co-payment limits.

- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.
- Consistency of payments to BCBSMT member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

Test Claims

Test claims were prepared and entered into the BCBSMT system to test various aspects of the system's capabilities. The test claims addressed the following:

- Duplicate claims.
- Duplicate claim logic.
- Claims for terminated individuals.
- Claims for terminated dependents.
- Claims from a fictitious provider.
- Claims for fictitious services.
- Claims involving coordination of benefits with another health care plan.
- Claims involving fees in excess of the usual, customary and reasonable limit established for the plan.
- Claims for procedures and/or diagnosis codes that are inconsistent with the patient's sex.

II - STATISTICAL CLAIM AUDIT RESULTS - STATE & MUS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 422 claims (211 claims for each plan sponsor).

The claims were selected from the population of claims paid by BCBSMT between January 1, 2002 and December 31, 2003. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 422 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 422 claims in our statistical sample, 9 were judged to contain a payment error. This represents a frequency of payment error of 2.1%.

Our sample contained a total payment of $7,175,718.18 for the 422 claims. The overpayments totaled $197,612.42 or 2.75% of the total. The underpayments totaled $.88 or 0.000% of the total. This financial error rate is less favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 1%.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 3%. However, the error rate is less favorable than the 1.2% error rate reported in the prior audit report.

There were no errors identified for the dental claims in our sample.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 0.5%, that the true frequency of error in the population is within the range of 1.6% to 2.6%.

Based on this extension, we believe that the true magnitude of payment error in the population is $242,696 or (0.17% of payments in the population). The magnitude of payment error is the sum of $242,650 in projected overpayments plus $46 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

A summary of error by type is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Application of pre-cert penalty.	1	100.00
Hospital discount application.	4	118,664.09
ESRD - Medicare COB	1	77,961.23
Other	3	886.22 (net)
Total	9	$197,611.54

BCBSMT has included their response as **Exhibit D**.

RECOMMENDATIONS

Our recommendations are as follows:

- During a portion of our audit period the MUS and the State utilized an outside vendor for repricing of inpatient hospital claims. As of August, 2003 these services were to be performed by BCBSMT. However, during a three month time period, claims for State employees were submitted with billed charges and BCBSMT was making payment with the assumption these claims had already been repriced. This has caused considerable overpayment of claims for the State (we identified $120,122.66). We believe BCBSMT should review all inpatient claims processed and paid during this time period and

Based on this extension, we believe that the true magnitude of payment error in the population is $242,696 or (0.17% of payments in the population). The magnitude of payment error is the sum of $242,650 in projected overpayments plus $46 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

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Other	3	886.22 (net)
Total	9	$197,611.54

BCBSMT has included their response as **Exhibit D**.

RECOMMENDATIONS

Our recommendations are as follows:

- During a portion of our audit period the MUS and the State utilized an outside vendor for repricing of inpatient hospital claims. As of August, 2003 these services were to be performed by BCBSMT. However, during a three month time period, claims for State and MUS employees were submitted with billed charges and BCBSMT was making payment with the assumption these claims had already been repriced. This has caused considerable overpayment of claims for the State and MUS (we identified $118,664.09). We believe BCBSMT should review all inpatient claims processed and paid during this

time period and reimburse the State and MUS for all overpayments, including our audit findings.

- We recommend BCBSMT reimburse the State for all overpayments made on the ESRD patient. We believe this individual's entire claim file has been overpaid.

III - STATISTICAL CLAIM AUDIT RESULTS - CHIP

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 211 claims.

The claims were selected from the population of claims paid by BCBSMT between January 1, 2002 and December 31, 2003. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 211 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 211 claims in our statistical sample, 15 were judged to contain a payment error. This represents a frequency of payment error of 7.1%.

Our sample contained a total payment of $1,569,764.94 for the 211 claims. The overpayments totaled $63.02 or .004% of the total. The underpayments totaled $101.96 or 0.006% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 1%.

The frequency of payment error in our sample is less favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 3%. This is the first claim audit for CHIP, therefore we cannot make any comparisons to previous audit results.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 1.2%, that the true frequency of error in the population is within the range of 5.9% to 8.3%.

Based on this extension, we believe that the true magnitude of payment error in the population is $5,340 or (0.03% of payments in the population). The magnitude of payment error is

the sum of $3,040 in projected overpayments plus $2,300 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type is presented below:

CHIP HEALTH CARE CLAIMS
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Application of mental health copays.	2	$ 28.00
Incorrect application of copay for services not requiring copay.	4	(14.00)
Incorrect application of copay for out-of-state claims (ITS).	6	32.02
Should have applied copay to office visit.	1	3.00
Incorrect denial of audiology services for newborns.	1	(87.96)
Total	15	$(38.94)

BCBSMT has included their response as **Exhibit D - 1** .

RECOMMENDATIONS

Our recommendations are as follows:

- We believe the identified errors during our audit are the result of incorrect programming in the BCBSMT claim payment system. We believe BCBSMT should communicate to

CHIP an action plan for correcting all identified programming errors.

- We idenfied several claims where subrogation (Third Party Liability) was potentially involved. We requested documentation on each of these claims. BCBSMT indicated to us that they only update the system with notes when the individual has submitted a response to the TPL letter issued by BCBSMT. We believe BCBSMT should be documenting all correspondence sent to a participant, in order to allow claim processors to have a complete understanding, at all times, as to the status of an investigation.

  We identified a claim that the automobile insurance made a payment to the hospital. However, BCBSMT did not reduce their payment to the hospital. BCBSMT indicates that since the amount reimbursed by the automobile insurance was less than the liability to the hospital that they do not reduce their payment. We believe this payment procedure is contrary to any practices identified in other insurance companies with which we are familiar.

IV - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT. This section describes the methods employed and presents the results of the verification of eligibility for the 633 (211 for the 3 plan sponsors) in our sample where a payment was made by BCBSMT.

STATE OF MONTANA

The State prepares and sends to BCBSMT a biweekly eligibility tape showing each individual to be covered for the coming month. BCBSMT runs this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

BCBSMT receives the enrollment data from each campus on a daily basis. BCBSMT then follows the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the BCBSMT's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

CHIP

CHIP prepares and sends to BCBSMT a monthly eligibility tape showing each individual to be covered for the month. BCBSMT then follows the same process as the State.

Eligibility Verification

Each of the CHIP participants in our sample was researched to verify that the BCBSMT's records indicated that coverage was in force on the date the services were rendered. CHIP's records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

V - BCBSMT REIMBURSEMENT

The State and MUS reimburse BCBSMT for claims paid on behalf of subscribers and their eligible dependents. BCBSMT credits the Plan Sponsors for overpaid claims once they are corrected.

CHIP submits to BCBSMT premiums on a monthly basis. This is based on the current month's enrollment in the Plan. A detailed bill is sent to CHIP prior to the premium payment.

The scope of our service included the measurement of the time required by the plan sponsors to reimburse BCBSMT for claims processed. The results of our test work is presented below.

REIMBURSEMENT PROCESSING TIME

BCBSMT submits invoices for reimbursement for claims paid during a certain period. The frequency of the invoices and the payment terms differ for each plan sponsor. Presented below is information regarding the contractual provision and the actual time required to reimburse BCBSMT based on records made available to us.

State of Montana

The State will bank wire transfer the requested amount within 48 hours of the receipt of a phone call from BCBSMT. BCBSMT then sends the State an invoice reflecting the amount requested.

We gathered invoices from January 1, 2002 through December 31, 2003 and measured the elapsed time between the phone call and the date payment was made by the State.

A total of 5 invoices were included in our review.

We noted that the state actually reimburses BCBSMT within 48 hours of the receipt of a phone call from BCBSMT. Therefore, the state reimburses BCBSMT before the receipt of the invoice. Upon receipt of the invoice from BCBSMT, the state compares the amount requested to the wire transfer confirmation.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from BCBSMT was paid within 48 hours of the phone call in all 5 cases.

Montana University System

MUS will bank wire transfer the amount within 48 hours of the receipt of the invoice.

We gathered invoices from January 1, 2002 through December 31, 2003 and measured the elapsed time between the receipt of the invoice and the date payment was made by MUS.

A total of 5 invoices were included in our review.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from BCBSMT was paid within 48 hours of the phone call in all 5 cases.

CHIP

CHIP will send the premiums once a month based on current month's enrollment. BCBSMT sends a detailed bill to CHIP for payment. The detailed bill is sent prior to premium payment.

We gathered invoices from January 1, 2002 through December 31, 2003 and measured the elapsed time between the receipt of the invoice and the date payment was made by CHIP.

A total of 3 invoices were included in our review.

We noted no exceptions when comparing the payment amount to the invoice amount. The amount invoiced from BCBSMT was paid within 10 working days in all 3 cases.

VI - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 633 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the date the claim was processed.

Results, by plan sponsor, are presented below.

State of Montana

For all 211 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	9
Median	2
Mode	0

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

MUS

For all 211 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	6
Median	0
Mode	0

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

CHIP

For all 211 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	4
Median	2
Mode	0

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

VII - COST CONTAINMENT

Discussion regarding cost containment procedures utilized at BCBSMT is presented below.

CASE MANAGEMENT

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. The notification procedure is used to alert APS Healthcare Northwest, Inc. (the case management firm utilized by the plans) of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, APS has indicated that they receive these referrals from BCBSMT and in some cases from the hospital.

This procedure is can be initiated by either the individual or the provider of services.

BCBSMT did not provide us with information regarding denied claims for any of the three plan sponsors.

SUBROGATION

All claims that indicate an accident and/or work related accidents are forwarded to the Subrogation Department. This Department then sets up the file and sends out a letter for details of the accident. Upon receipt of the letter, BCBSMT then sends the appropriate letter(s) in order to: (1) assert their subrogation right, (2) notify participant that the Third Party Liability coverage is primary to the plan, or (3) recover payments made related to a work related injury.

Subrogation recovery information by plan sponsor is presented below.

The State of Montana

The State's recovery information is detailed below.

Year	Auto/Medical	Subrogation	ITS (Blue Card)	Workers' Comp
1998: Recovery	($51,485.60)	$26,194.44	$13,210.73	($45,442.50)
Savings	175,922.90	31,828.04	0.00	134,190.50
1999: Recovery	(3,797.11)	36,972.67	12,718.12	50,960.27
Savings	71,130.31	25,816.17	0.00	83,304.64

2000: Recovery	18,143.31	21,858.78	13,988.66	37,802.43
Savings	70,975.74	33,217.41	114,068.58	0.00
2001: Recovery	(38,832.58)	73,850.84	5,736.33	79,115.95
Savings	127,987.48	40,491.34	0.00	185,835.91
2002: Recovery	(84,812.05)	19,418.99	844.00	(28,752.44
Savings	183,439.33	53,461.49	0.00	226,786.17
2003: Recovery	18,285.92	37,750.44	Not Reported	75,626.07
Savings	179,310.41	5,554.43	Not Reported	140,248.47

MUS

MUS's recovery information is detailed below.

Year	Auto/Medical	Subrogation	ITS (Blue Card)	Workers' Comp
1998: Recovery	($3,631.51)	$24,281.90	$993.70	($21,327.55)
Savings	33,767.38	3,266.86	0.00	15,196.59
1999: Recovery	40,416.77	17,157.70	615.30	47,949.71
Savings	36,593.54	4,952.87	0.00	31,564.47
2000: Recovery	5,078.15	11,888.61	1,315.50	17,757.57
Savings	13,224.94	9,279.09	0.00	98,726.63
2001: Recovery	(7,030.39)	19,548.71	628.00	11,046.76
Savings	40,508.62	9,642.57	0.00	27,253.91
2002: Recovery	5,984.20	26,923.16	0.00	31,834.77
Savings	30,196.22	46,408.89	0.00	63,933.57
2003: Recovery	16,235.19	36,110.50	Not Reported	24,257.35
Savings	44,001.91	1,461.52	Not Reported	27,925.97

FRAUD INVESTIGATION

An active fraud investigation function is an effective deterrent to those who may consider such activities.

BCBSMT has developed a fraud investigation program, which includes the following:

- Fraud Awareness Program for all claim processors and customer service representatives.
- EOBs are sent to the patient for every claim submitted to BCBSMT for processing.
- BCBSMT has developed a web site, for which participants may access to report possible fraud.
- BCBSMT had established a fraud hotline, which is indicated on each EOB received by the member. The web site address is listed on every EOB the member receives.
- Every out-of-state, non-network doctor is researched for licensure information from the appropriate State Board of Physicians by the BCBS plan where the provider is licensed.
- The BCBSMT claim system has the ability to flag providers that have been identified as having questionable billing practices.
- BCBSMT became a corporate member of the National Health Care Anti-Fraud Association (NHCAA) in 2001. NHCAA membership is comprised of numerous private and public sector organizations and individuals including various law enforcement agencies and 25 individual Blue Cross Blue Shield plans.
- BCBSMT developed a new corporate fraud awareness program in 2001, and training of employees from the Member Services and Support area began in the fall of 2001.

Recoveries

Recovery information for the years 1998, 1999, 2000, 2001, 2002 and 2003 is for all BCBSMT's book of business is presented below.

Year	Recovery
1998	$143,994.78

1999	$ 84,107.10
2000	$ 96,986.00
2001	$270,936.00
2002	$571,051.00
2003	$440,916.00

The above recovery dollars is based on actual recoveries, rather than projected savings.

Based on our review we conclude that the investigative procedures and staff training are further advanced than many administrators.

Note: CHIP is a fully insured plan. Therefore, these recovery numbers are not tracked individually for CHIP.

VIII - LOGIC AND OTHER TEST RESULTS

This section presents the results of test claims submitted to the BCBSMT claim system as a method of assessing the system's ability to identify inappropriate transactions. The tests and the results are discussed below.

To protect against issuance of actual check payments and contamination of member history, a test cycle was used for all test claims.

Duplicate Claims

The claim system contains a series of edits designed to identify duplicate claims. If an exact match with a previously processed claim, the claim is rejected as a duplicate.

To test the system's duplicate claim logic, we selected four previously processed claims. Each claim was altered as follows:

- Change the diagnosis.
- Change the billed amount.
- Change the provider code.

This resulted in twelve separate resubmissions, each with one of the above changes made. In each case, the system correctly identified the fictitious resubmissions as a duplicate claim.

Finally, we submitted 10 previously processed claims.

The system correctly identified the 10 claims as duplicates.

Overcharging By Providers

BCBSMT has developed fee allowances for professional services. Our review confirmed that the system will correctly calculate the allowance.

We submitted five fictitious test claims where the provider's fee exceeded the allowance. The claim processing system correctly identified all five overcharges and reduced the allowance to agree with the appropriate amount.

Unnecessary Physician Services

The claim system has several edits designed to identify potentially unnecessary physician services. These edits involve matching diagnosis codes to procedure codes, monitoring the frequency of service and comparing the procedure to the patient's sex. In addition, claims from

providers with a history of abuses or suspect billing practices are suspended for further evaluation prior to payment.

As part of our test work, we prepared and submitted five fictitious test claims where the patient's sex was not consistent with the procedure/diagnosis. All five of the claims were correctly identified as inconsistent with the patient's sex.

We also submitted five test claims involving fictitious type of service codes. All five claims were correctly suspended as containing invalid codes.

Other Test Claims

Additional test claims processed are discussed below.

Terminated Employees and Dependents

We submitted ten fictitious claims (five for employees and five for dependents) for individuals whose coverage had terminated. Each date of service followed the date coverage terminated. The system correctly rejected all 10 of the claims as claims incurred following termination of coverage.

Fraudulent Providers

We submitted five test claims from a fictitious provider. The test claims were entered. However, according to procedures, when an invalid provider number was entered, the processor would forward the claim to the Provider Maintenance Department where further investigation is performed.

Coordination of Benefits

Five fictitious claims were prepared for individuals whose history file indicated that other insurance coverage was present. All five of these claims were suspended for COB information.

SUMMARY

Based on our test results, we conclude that the BCBSMT system is effective in identifying erroneous claims.

Test Claim Summary

The findings from the fictitious claim testing are summarized as **Exhibit C** attached to this report.

IX - OTHER REVIEW AREAS

The results of our review in areas requested by the three plan sponsors is as follows.

SUSPENDED CLAIMS

We requested reports from BCBSMT regarding the percentage of claims submitted that were suspended, reasons for suspension, and the average length of time before these claims were paid or denied.

BCBSMT did not provide the requested information for any of the three plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

DENIED CLAIMS

We requested reports from BCBSMT regarding the number of claims denied, including provider type, amount and if there were multiple denied claims for one provider. In addition, determine the percentage denied due to ineligibility of a member.

BCBSMT did not provide the requested information for any of the three plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

PHARMACY CLAIMS - CHIP

We were requested to review the pharmacy plan for a formulary and analyze a sample of denied pharmacy claims.

BCBSMT does not use a drug formulary for CHIP. Therefore, no copy of that plan is included in this report.

BCBSMT also indicated to us that there are no denied pharmacy claims for CHIP members. Therefore, there were no claims to review.

However, CHIP has indicated to us that staff members have received phone calls from family members of eligible CHIP children who were unable to obtain a prescription for their CHIP children, where full payment was required by the member. These individual situations have been resolved with intervention with BCBSMT. Therefore, there are denied claims for CHIP members, but BCBSMT was unable to provide this information.

BCBSMT does not track these instances.

We did verify with BCBSMT that co-pay accumulators for medical and pharmacy are combined electronically, in order to avoid a participant from exceeding their maximum out-of-pocket copay. We also ran accumulator reports for 5 individuals, in order to verify that the process is being done appropriately. No exceptions were identified.

RESERVES & ADMINISTRATIVE EXPENSES - CHIP

We were requested to provide information regarding the use of reserves from the CHIP account and obtain a breakdown of administrative expenses for the plan.

For 2002-2003, BCBSMT indicated to us that they credited the claims account for 75% of the reserve amount and contributed the remaining 25% to the Caring Program for Children. No interest was accounted for in this distribution. BCBSMT indicated to us that the account was "probably" an interest bearing account.

After reviewing the contract, there is no mention regarding reserves for the plan.

BCBSMT did not provide a breakdown of administrative expenses for the plan. Therefore, we cannot include this in the report. However, they indicate to us that they provide this information to CHIP on a yearly basis during the renewal process. CHIP has indicated to us that BCBSTMT does not include a breakdown of administrative expenses for the plan, rather it's just an overall total of administrative expenses.

Comment

We believe there have been considerable misunderstandings regarding the reserves for the plan. We recommend that BCBSMT and CHIP discuss the possibility of a reserve agreement.

We also believe that BCBSMT and CHIP should discuss rate increases, including administrative expenses. There is no discussion of limiting rate increases in the contract between BCBSMT and CHIP.

We further believe that a more thorough review of the financials of the CHIP plan, with regards to BCBSMT premiums and reserves, should be performed by accounting professionals.

INPATIENT MENTAL HEALTH - CHIP

We were requested to review the use of out-of-state mental health providers and attempts by BCBSMT to secure the lowest reimbursement rate from both in-state and out-of-state from these providers.

During our review of 211 claims for CHIP, we did identify claims for both out-of-state and in-state mental health providers. We noted that for both in-state and out-of-state, the BCBS network provided for discounts from these providers. If the participant is subject to case management, they will make an attempt to secure a discount from any non-network providers (also network providers if the care is deemed to be long-term).

Out-of-state providers are only used, when in-state providers do not have the necessary space and/or services required for the patient's treatment. Our understanding is that there is not many in-state facilities to treat severe mental health conditions. Therefore out-of-state facilities are typically utilized, in order to provide adequate treatment for the patient.

X - PRIOR AUDIT RECOMMENDATIONS

The most recently completed audit for the State of Montana and Montana University System (The Montana Power Company was included), prior to this audit, was performed for the period January 1, 2000 through December 31, 2001.

The report for that audit, issued in April, 2002, contained the following recommendations:

LIFETIME MAXIMUM

During our test work regarding the calculation of the State's $1,000,000 lifetime maximum provision, we noted that BCBSMT must manually monitor the accumulation of benefits of both system claims and archived claims for participants with high utilization.

We believe the manual monitoring procedure may result in inaccurate processing of claims in excess of the lifetime benefit. Therefore, we recommend BCBSMT establish a program that automatically accumulates the benefits of both archived claims and system claims.

Comment

There have been no changes to this procedure. However, BCBSMT has indicated to us that with the new claim processing system (August, 2004) that this procedure will be automated.

OFFICE VISIT COPAYS

During our test work of the sample claims, we identified a situation where a State employee went to two different doctors in one day. BCBSMT only applied one $15.00 co-pay, which is their policy on all their lines of business. We believe this was not in accordance with the State's plan provision for a $15.00 co-pay per office visit.

We requested BCBSMT to verify that the State was in agreement with this procedure. The State was not in agreement and was not aware that this procedure was in place at BCBSMT.

We believe BCBSMT should reimburse, to the State, the overpayments caused by this procedure.

Comment

We did not identify any similar situation during our audit. BCBSMT has modified their policy to reflect the intentions of the State plan.

LARGE CASE MANAGEMENT

During our audit of the 600 sample claims, we identified two high dollar claims that were not subject to Large Case Management. However, other claims for the two patients were subject to Large Case Management.

We believe earlier intervention with Large Case Management could have provided discounts on these large hospital bills. We recommend BCBSMT encourage earlier intervention on these high dollar claims.

Comment

BCBSMT has indicated to us that they make an aggressive attempt to provide large case management for potential high dollar claimants.

"PIGGYBACK" CLAIMS

BCBSMT processes some preventive claims as "piggyback", meaning the claim will process on the preventive level first and if the charges exceed the preventive maximum, the claim will then process on the medical level where deductible and coinsurance limits are applied.

We believe this process contradicts the preventive limits outlined in the plan documents.

We recommend BCBSMT discuss this procedure with the State and MUS. In the event, of the State and MUS disagree, we believe BCBSMT should review all claims affected by this procedure and refund overpayments to the Plan Sponsors and adjust deductible and/or coinsurance accumulators.

Comment

BCBSMT has not made any changes in their claim payment process at the clients request.

EXHIBIT A

STATE OF MONTANA & UNIVERSITY OF MONTANA
HEALTH CARE CLAIM AUDIT
CLAIMS PROCESSED FROM JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF FINDINGS

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
42355813931	UNIVERSITY	1.25	0.00	1.25	Payment should have been applied to the deductible.
42254847770	STATE	96,065.86	95,965.86	100.00	Inpatient stay was not precertified.
12114103980	STATE	5,639.35	5,640.23	(0.88)	Member's out of pocket maximum is over by $.88.
12123109370	STATE	5,834.26	4,948.41	885.85	Should have applied co-ins.
02310007210	UNIVERSITY	94,704.55	61,557.96	33,146.59	Should have applied discount.
03104005060	STATE	184,406.96	119,864.52	64,542.44	Should have applied discount.
03104005020	STATE	49,451.90	32,143.74	17,308.16	Should have applied discount.
03104005040	UNIVERSITY	50,315.91	46,649.01	3,666.90	Should have applied discount.
42301847560	STATE	77,961.23	-	77,961.23	ESRD COB error. Claim should have been coordinated with Medicare.
TOTALS		564,381.27	366,769.73	197,611.54	

EXHIBIT B

CHILDREN'S HEALTH INSURANCE PLAN
SUMMARY OF FINDINGS
AUDIT PERIOD JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

CLAIM #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
13126100280	2,040.64	2,026.64	14.00	Should have applied $5 co-pays for mental health, not $3.
13101100460	2,040.64	2,026.64	14.00	Should have applied $5 co-pays for mental health, not $3.
02350005200	4,126.75	4,131.75	(5.00)	Applied 2 ER copays when ER visit spanned 2 days.
03178216190	189.08	192.08	(3.00)	Applied copay in error to anesthesia claim.
12281107910	4,058.31	4,061.31	(3.00)	Should not have applied $3 copay for outpatient services. $5 copay was applied.
42085836290	101,941.71	101,941.24	0.47	ITS claim did not apply full $25 inpatient copay.
41363837000	4,208.95	4,196.95	12.00	ITS claim did not apply full $25 inpatient copay.
03105210290	218.00	215.00	3.00	Should have applied $3 copay for office visit.
41346830430	115,018.08	115,014.35	3.73	ITS claim did not apply full $25 inpatient copay.
43254805870	212.45	210.30	2.15	ITS claim did not apply full $25 inpatient copay.
42227835440	85,088.89	85,087.09	1.80	ITS claim did not apply full $25 inpatient copay.
13118327370	189.08	192.08	(3.00)	Should not have applied co-pay to anesthesia claim.
42026828450	26,336.87	26,325.00	11.87	ITS claim did not apply full $25 inpatient copay.
13223100130	32,095.90	32,139.88	(43.98)	Audiology charge on a newborn inpatient claim was denied in error.
13223100110	32,813.43	32,857.41	(43.98)	Audiology charge on a newborn inpatient claim was denied in error.
TOTALS	410,578.78	410,617.72	(38.94)	

Exhibit C

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
RESULTS OF SYSTEM TESTS

	RESULTS		
TEST	**PASS**	**FAIL**	**COMMENT**
Duplicate Claims Tests	All 10		
Logic Claims Tests			
Change Diagnosis	4		
Change Billed Amount	4		
Change Provider Code	4		
Other Claims Tests			
Terminated Member	All 5		
Terminated Dependent	All 5		
Fictitious Provider	All 5		
Fictitious Service Code	All 5		
COB Claims	All 5		
Test/Allowable Data	All 5		
Inconsistent With Sex	All 5		

BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

December 3, 2004

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Traditional Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana Traditional claim audit recently completed for the audit period January 1, 2002 through December 31, 2003.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings in Exhibit A, and Recommendations.

Claim	
42355813931	"Payment should have been applied to the deductible." The claim is overpaid $1.25 (MUS) **Comment:** BCBSMT agrees with this finding. There is a problem in the ITS system with deductible/copay calculation.
23108713781	"Billed as new patient. However the provider had seen the participant before." Claim is overpaid $2.28 (MUS) **Comment:** BCBSMT disagrees with this finding. This member has Medicare prime. The Medicare coinsurance, which is calculated by Medicare, on assigned claims, is the only BCBSMT responsibility. If Medicare accepts and processes the claim with the codes submitted by the provider, BCBSMT honors the same codes and processes.
12218318470	"Paid for routine exam with no connection with an illness or accident." Claim is overpaid $50.00 (MUS)

Comment: BCBSMT disagrees with this finding. This claim was paid under the preventive benefit per Page 65 of the of the benefit booklet. "3) Routine prostate exam. This exam is normally recommended for males ages 50 and older, not to exceed $50 for such an exam each year.

42254847770

"Inpatient stay was not precertified." The claim is overpaid $100.00 (State)

Comment: BCBSMT disagrees with this finding. The member was admitted to the hospital for severe trauma and cerebral injuries as the result of a motor vehicle accident. The Summary Plan Document indicates that if no one calls in for certification the hospital stay it will be reviewed after the fact. Penalty for not precertifying the hospital stay would include denying room charges unnecessary for the treatment of the patient. Review indicates due to the severity of the injuries and patient condition hospital stay was warranted.

12114103980

"Member's out of pocket maximum is over by $.88." The claim is underpaid $.88 (State)

Comment: BCBSMT agrees with this finding.

12123109370

"Should have applied co-ins." The claim is overpaid $1458.57 (State)

Comment: BCBSMT agrees with this finding but disagrees with the overpaid amount. This claim was for newborn charges at St Peters Hospital, which is a preferred facility. The copay on a preferred facility is 15% and the MML (out of pocket) is $900 for preferred providers. The total charge of the claim is $5905.65. $5905.65 x 15% = $885.85 copay due from member. The true overpayment is $885.85 not $1458.57.

02310007210

"Should have applied discount." The claim is overpaid $33,146.59 (State)

Comment: This claim has been adjusted to apply the discount as submitted hard copy by the facility. Please see HDI discount comment below.

03104005060	"Should have applied discount." The claim is overpaid $64,542.44 *This was incorrectly listed in Exhibit A as the State group. The correct group is MUS.* **Comment:** This claim has been adjusted to apply the discount as submitted hard copy by the facility. Please see HDI discount comment below.
03104005020	"Should have applied discount." The claim is overpaid $17,308.16 *This was incorrectly listed in Exhibit A as the State group. The correct group is MUS.* **Comment:** This claim has been adjusted to apply the discount as submitted hard copy by the facility. Please see HDI discount comment below.
03104005040	"Should have applied discount." The claim is overpaid $3,666.90 *This was incorrectly listed in Exhibit A as the State group. The correct group is MUS.* **Comment:** This claim has been adjusted to apply the discount as submitted hard copy by the facility. Please see HDI discount comment below.

HDI Discount Comment: BCBSMT agrees these claims (all for St Patrick Hospital) are overpaid and agrees with the amounts, however we disagree this is a BCBSMT processing error.

These discount amounts were arranged outside of our provider contracts and as such discounts were "invisible" to BCBSMT. The Montana Association of Health Care Purchasers (MAHCP) negotiated with Hospitals on behalf of the State of Montana, Northwestern Energy and Montana University Systems. These negotiated agreements are primarily with HDI (Health Dynamics Inc) but also include some independent hospitals.

Prior to 8/15/02, all claims received by BCBSMT (through Health-E Web) from hospitals contracted with HDI already had the "invisible" discount applied to the charges. BCBSMT did not have access to the original charge or the amount of the discount and processed the claim based on the already discounted charge submitted on the claim. Questions regarding the discount amounts from providers were to be directed to HDI and questions from the members were to be directed to the group leaders.

Starting 8/15/02 claims from all but two hospitals (St Patrick Hospital, Missoula and Saint Vincent Hospital, Billings) were discounted in-house by BCBS of MT. Claims from St. Patrick and Saint Vincent Hospitals continued to be discounted with the same procedure used prior to 8/15/02.

There was a problem with claims submitted to BCBSMT having an incorrect discount or no discount, resulting in several hundred claims requiring adjustment during the months of July, August, and September 2002. BCBSMT worked closely with Don Creveling of HDI to adjust these claims to reflect the correct discount amounts. It is our assumption the incorrect claims identified in the audit were not addressed (by HDI) with the proper person at BCBSMT for entry/adjustment.

42301847560	"ESRD COB error. Claim should have been coordinated with Medicare." Overpaid $77,961.23 (State) **Comment:** BCBSMT agrees that this claim is overpaid but disagrees with the amount and that it is due to BCBSMT processing error. The overpayment amount cannot be determined until Medicare has processed this claim. In May 2004 BCBSMT discovered that the BCBSMT primacy was incorrect. The information from the Social Security office, provided to Medicare and BCBSMT, indicated that Medicare eligibility was due to disability. BCBSMT has worked extensively with Medicare to adjust these claims for Medicare to pay prime. We also contacted Paul Bogumill, at the State, to explain the situation and get his input on how we should proceed. He wanted to us to go back to the Medicare primacy date and adjust all claims that BCBSMT paid primary, which we are currently doing.

II-3 RECOMMENDATIONS

- "During a portion of our audit period the MUS and the State utilized an outside vendor for repricing of inpatient hospital claims. As of August 2003 these services were to be performed by BCBSMT. However, during that three month time period, claims for State employees were submitted with billed charges and BCBSMT was making payment with the assumption these claims had already been repriced. This has caused considerable overpayment of claims for the state (we identified $120,122.66). We believe BCBSMT should review all inpatient claims processed and paid during this time period and reimburse the State for all overpayments, including our audit findings. We do not think that this warrants a separate audit by Wolcott & Associates, Inc. We

believe the issue has been resolved. However, overpayments during that time period may still exist."

Comment: Please refer to the HDI Discount Comment in Exhibit A. As of August 2002, not 2003 BCBSMT was "repricing" the claims except for Saint Vincent and St Patrick Hospitals. All of the claims reported in the findings were submitted by St Patrick Hospital, and have been adjusted. Not all of these claims were for the State group. There were actually 3 claims with a total overpayment $85,517.50 for MUS and 1 claim with at total overpayment of $33,146.59 for the State. BCBSMT could only find $118,664.09 total overpayment for both groups. It appears the additional $1,458.57 included in your total may have inadvertently been pulled from the claim identified for and incorrect copay amount (12123109370).
Because this problem was identified prior to the audit and hundreds of claims have already been adjusted, BCBSMT feels the number of outstanding claims will be minimal. BCBSMT will however work with the groups to identify any other claims that may require adjustment.

- "We recommend BCBSMT reimburse the State for all overpayments made on the ESRD patient. We believe this individual's entire claim file has been overpaid."

Comment: As noted in Exhibit A, we have already begun working with the State, in June, and adjusting claims for overpayment.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

Exhibit D-1

BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

December 1, 2004

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Children's Health Insurance Plan Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Children's Health Insurance Plan claim audit recently completed for the audit period January 1, 2002 through December 31, 2003.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings in Exhibit B, and Recommendations.

Claim	
13126100280	"Should have applied $5 co-pays for mental health, not $3." The claim is overpaid $14.00 **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04.
13101100460	"Should have applied $5 co-pays for mental health, not $3." The claim is overpaid $14.00 **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04.
02350005200	"Applied 2 ER copays when ER visit spanned 2 days." This claim is underpaid $5.00 **Comment:** BCBSMT disagrees with this finding. CHIP contract language indicates a $5 copay is applicable for an ER visit. A $5 copay is also applicable for outpatient hospital visits

that do not include an ER charge and if the services are for more than just lab and/or x-ray. The patient was seen in the ER on 12/05 and had surgery on that same date. The hospital billed 7 hours of observation room for 12/05 and 10 hours of observation room for 12/06. $5 copay for outpatient service on 12/06 is applicable.

03178216190 "Applied copay in error to anesthesia claim." This claim is underpaid $3.00

Comment: BCBSMT agrees with this finding. As a result of this finding, BCBSMT corrected the system coding 10/06/04.

12281107910 "Should not have applied a $3 copay for outpatient services. $5 copay was applied." This claim is $3.00 underpaid

Comment: BCBSMT agrees with this finding. The system was incorrectly coded to apply a $3 copay for outpatient therapy in all circumstances. As a result of this finding BCBSMT has initiated the correction for system coding.

42085836290 "ITS claim did not apply full $25 inpatient copay." This claim is overpaid $.47

Comment: BCBSMT agrees with this finding. There is a problem in the ITS system with copay calculation.

41363837000 "ITS claim did not apply full $25 inpatient copay." This claim is overpaid $12.00

Comment: BCBSMT agrees with this finding. There is a problem in the ITS system with copay calculation.

03105210290 "Should have applied $3.00 copay for office visit." This claim is overpaid $3.00

Comment: BCBSMT agrees with this finding. This is an adjusted claim. The resulting error was due to a manual error in the adjustment.

41346830430	"ITS claim did not apply full $25 inpatient copay." This claim is overpaid $3.73 **Comment:** BCBSMT agrees with this finding. There is a problem in the ITS system with copay calculation.
43254805870	"ITS claim did not apply full $25 inpatient copay." This claim is overpaid $2.15 **Comment:** BCBSMT agrees with this finding; however, this claim was an outpatient professional claim and should have been a $3 copay and only an $.85 copay was applied. There is a problem in the ITS system with copay calculation.
42227835440	"ITS claim did not apply full $25 inpatient copay." This claim is overpaid $1.80 **Comment:** BCBSMT agrees with this finding. There is a problem in the ITS system with copay calculation.
13118327370	"Applied copay in error to anesthesia claim." This claim is underpaid $3.00 **Comment:** BCBSMT agrees with this finding. As a result of this finding, BCBSMT corrected the system coding 10/06/04.
42026828450	"ITS claim did not apply full $25 inpatient copay." This claim is overpaid $11.87 **Comment:** BCBSMT agrees with this finding. There is a problem in the ITS system with copay calculation.
13223100130	"Audiology charge on newborn inpatient claim was denied in error." Claim is underpaid $43.98 **Comment:** BCBSMT agrees with this finding. As a result of this finding, BCBSMT corrected the system coding 10/12/04.
13223100110	"Audiology charge on newborn inpatient claim was denied in error." Claim is underpaid $43.98

Comment: BCBSMT agrees with this finding. As a result of this finding BCBSMT corrected the system coding 10/12/04.

III-3 & III-4 RECOMMENDATIONS

- "We believe the identified errors during our audit are the result of incorrect programming in the BCBSMT claim payment system. We believe BCBSMT should communicate to CHIP an action plan for correcting all identified programming errors."

Comment: As noted in the comments for Exhibit B, BCBSMT has corrected the LRSP copay coding errors identified in the audit specific to claims that are not processed through the BlueCard Program.

BCBSMT will not be making any changes in the coding for the copay error in the claims processed through the BlueCard Program. Low volume of claims affected and low dollar payment errors do not justify the cost effectiveness of changing the system coding at this time. BCBSMT is in the process of converting to a new system. The copay coding errors identified on BlueCard claims have already been addressed and coding is in place on the new system to ensure the correct copay amounts are applied.

CHIP is not a self-insured program and is underwritten by BCBSMT. BCBSMT shares in any surplus with DPHHS but is solely responsible for any losses for this group. For this reason, BCBSMT applies standard business practices to these claims. It is BCBSMT standard business practice to not adjust claims for under/over payment of less than $25.00 because it is not cost effective. BCBSMT, therefore, will not be adjusting any of the payment errors identified.

- "We identified several claims where subrogation (Third Party Liability) was potentially involved. We requested documentation on each of these claims. BCBSMT indicated to us that they only update the system with notes when the individual has submitted a response to the TPL letter issued by BCBSMT. We believe BCBSMT should be documenting all correspondence sent to a participant, in order to allow claim processors to have a complete understanding, at all times, as to the status of an investigation."

Comment: Please refer to the CHIP Accident memo dated 10/14/04. The problem with documentation occurred because TPL letters were not being sent on CHIP members. A fix was implemented on the system 10/25/04 so that an accident query letter is system generated and sent to the member. BCBSMT has

always documented any correspondence sent to and received from "participants". In these instances, there was no correspondence to document.

- "We identified a claim where the automobile insurance made a payment to the hospital. However, BCBSMT did not reduce their payment to the hospital. BCBSMT indicates that since the amount reimbursed by the automobile insurance was less than the liability to the hospital, they do not reduce their payment. We believe this payment procedure is contrary to any practices identified in other insurance companies with which we are familiar."

Comment: CHIP is not a self-insured program and is underwritten by BCBSMT. BCBSMT shares in any surplus with DPHHS but is solely responsible for any losses for this group. For this reason, BCBSMT applies standard business practices to these claims. It is BCBSMT standard business practice to apply TPL payment to the actual charges on the claim not the discounted amount. In no instance does BCBSMT reimburse more than the actual charge.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

Exhibit E

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION
STATE OF MONTANA

Mitchell Building, Room 130
PO Box 200127
Helena Montana 59620-0127

(406) 444-3871
FAX: (406) 444-0703
http://discoveringmontana.com/doa/spd/css/

December 1, 2004

Marie Pollock, HIA
Vice President
Wolcott & Associates, Inc.
12120 State Line Road, Suite 297
Leawood, Kansas 66209

Subject: Analysis and Evaluation of Claims Processing (Blue Cross Blue Shield of Montana) for the Period January 1, 2002 through December 31, 2003

Dear Ms. Pollock:

We received your draft report on the State of Montana Analysis and Evaluation of Claims Processing (Blue Cross Blue Shield of Montana) for the period January 1, 2002 through December 31, 2003, and we provide the following responses to your audit findings and recommendations.

Statistical Claims Audit Results

We concur with the recommendations listed by Wolcott & Associates, Inc. regarding BCBSMT adjudication of State of Montana Plan claims. The State is currently discussing with BCBSMT the process for correcting the re-pricing on inpatient hospital claims during three months of 2003, which constituted a substantial majority of the errors identified. We have also worked with BCBSMT to correct the overpayment made on the end-stage renal disease (ESRD) patient.

Thank you for providing us with the opportunity to respond to the recommendations.

Sincerely,

Connie Welsh

Connie Welsh, Chief
Employee Benefits Bureau

Exhibit F

MONTANA UNIVERSITY SYSTEM
Office of the Commissioner of Higher Education

2500 Broadway ◊ PO Box 203101 ◊ Helena, Montana 59620-3101 ◊ (406)444-6570 ◊ FAX (406)444-1469

December 3, 2004

Marie Pollock
Wolcott & Associates, Inc
12120 State Line Road, Suite 297
Leawood, Kansas 66209

RE: State of Montana, Montana University System, CHIP Claims Audit

Dear Ms Pollock:

Thank you for the opportunity to respond to your audit of the Montana University System employee group insurance plan as administered by Blue Cross Blue Shield of Montana. Your audit indicates that BCBSMT's claims processing error rate has slipped a little since your last audit. It is good to note that BCBSMT is meeting or exceeding other evaluation criteria, especially in fraud investigative procedures. The Montana University System has been discussing and will follow-up on the discount issue with BCBSMT and HDI.

Thank you for the effort you and your staff put in on this audit.

Sincerely,

Glen D Leavitt

Glen D. Leavitt
Director of Benefits

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

Exhibit G

JUDY MARTZ
GOVERNOR

GAIL GRAY, Ed.D.
DIRECTOR

STATE OF MONTANA

www.dphhs.state.mt.us

PO Box 4210
HELENA, MT 59604-4210

December 1, 2004

TO: Marie Pollock
Wolcott & Associates, Inc.

FROM: Mary Noel, Chief
Health Care Resources Bureau

SUBJECT: Response to draft report of BCBSMT audit report, November 2004, for the Children's Health Insurance Plan (CHIP)

I. Introduction

Fourth paragraph: Please revise this paragraph to read: "The Children's Health Insurance Plan (CHIP) is administered by the Department of Public Health and Human Services (DPHHS), and provides a fully insured medical care and prescription drug plan to qualifying children in the State of Montana. The plan covers approximately 11,000 children."

III. Statistical Claim Audit Results—CHIP

Exhibit B and summarized on page III-3

A. Claim #s 13126100280 and 13101100460: Are these outpatient hospital visits? If not, the copay is $3, not $5.

B. Claim # 12281107910: The explanation is confusing, please clarify. Is this outpatient hospital?

V. BCBSMT Reimbursement

Page V-1, second paragraph states, "CHIP submits to BCBSMT premiums on a monthly basis. This is based on the previous month's enrollment in the Plan."

Premiums paid by DPHHS are for the *current* month's enrollment, not the *previous* month's enrollment. Please correct.

Page V-2, first paragraph under CHIP states, "CHIP will send the premiums once a month based on previous month's enrollment. BCBSMT sends a detailed bill to CHIP for payment."

Premiums paid by DPHHS are for the *current* month's enrollment, not the *previous* month's enrollment. Please correct. In addition, BCBSMT's detailed bill is received by DPHHS *before* the premium payment is made. Please revise the first paragraph to reflect this.

The final sentence on the page states, "The amount invoiced from BCBSMT was paid within 10 working days in all 3 cases."

The premium payment is always made within one (1) day of receiving BCBSMT's detailed bill. I know one day is "within 10 working days" but I would like the report to reflect that DPHHS pays the premium with one day. If you have information that does not support this, please let me know.

VII. Cost Containment

Page VII-1, third paragraph states, "Typically, participants are referred to case management based on diagnosis. However, APS has indicated that they receive these referrals from CHIP and in some cases from the hospital."

Throughout the report, the term "CHIP" is used to refer to the DPHHS program. In this paragraph, the term "CHIP" should be changed to "BCBSMT" as DPHHS does not make referrals to APS.

XI. Other Review Areas

A. Pharmacy Claims—CHIP, page IX-1

Third paragraph states, "BCBSMT also indicated to us that there are no denied pharmacy claims for CHIP members. Therefore, there were no claims to review."

CHIP staff members have received telephone calls from family members of eligible CHIP children who were unable to obtain a prescription for their CHIP children, were required to pay more than their copayments, if applicable, or were required to pay full price for the medications. These individual situations have been resolved when CHIP staff members intervene with BCBSMT. However, we do not know the true magnitude of this issue as there may be children whose family members do not call the CHIP office when they encounter problems at their pharmacies.

If BCBSMT does not track or record these instances, please include a statement in the report to that effect.

Is there another way you can obtain this information? If BCBSMT doesn't keep records, would Express Scripts, Inc. be able to provide it?

B. Reserves & Administrative Expenses—CHIP, page IX-2

First paragraph states, "BCBSMT indicated to us that there was no reserve agreement for the audit period 2002-2003." There was in fact an agreement that was understood by

DPHHS to be in place, however, I do not want to reopen this debate in the report. The information we were looking for was what BCBSMT did with the funds they retained and called reserves. If BCBSMT did not provide a breakdown of how the money was used, please just state that in the report. Please remove the first sentence of this paragraph.

C. Third paragraph states, "BCBSMT did not provide a breakdown of administrative expenses for the plan. Therefore, we cannot include this in the report. However, they indicate to us that they provide this information to CHIP on a yearly basis during the renewal process."

In fact, BCBSMT does not provide a breakdown of administrative expenses during the renewal process—they provide a total of the administrative expenses. That is why we asked for a detailed breakdown as part of the audit. Please remove the last sentence of this paragraph from the report or clarify to include the DPHHS position.

D. Comment

Second paragraph: To which Montana law do you refer when you state there are rate increases and administrative expenses that "may disagree with Montana State Law?" Please clarify.

Third paragraph: Please clarify and expand. To which "financials of the CHIP plan" do you refer? When you say "BCBSMT reimbursement," are you referring to the premium paid by DPHHS? What "accounting professionals" do you recommend—internal, external?

STATE OF MONTANA and MONTANA UNIVERSITY SYSTEM,

PRESCRIPTION DRUG CLAIM AUDIT

FOR THE PERIOD

JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

ADMINISTERED BY

ECKERD HEALTH SERVICES

FINAL REPORT

DECEMBER, 2004

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LANE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA
PRESCRIPTION DRUG PLAN AUDIT
OF ECKERD HEALTH SERVICES
JANUARY 1, 2002 - DECEMBER 31, 2003

TABLE OF CONTENTS

I - INTRODUCTION

The State of Montana (State) provides a prescription drug benefit as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered.

The State is a member of the Montana Association of Health Care Purchasers. The Assocation has negotiated a contract with TDI Managed Care Services, Inc. d/b/a/ Eckerd Health Services (EHS) to provide prescription drug benefits to employees and Association members that elect such benefits. The State has elected to have its prescription drug benefits provided by EHS.

The Montana University System (MUS), has contracted directly with EHS for the provision of prescription drug benefits. The plan covers approximately 6,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. The Division issued a bid request on May, 2004, for the performance of this audit. Wolcott & Associates, Inc. was awarded the audit contract.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Division advised Wolcott & Associates, Inc. that we had been awarded the audit contract. All preliminary work was completed and the entrance meeting was held in Helena on September 8, 2004.

The on-site work started on October 5, 2004 at EHS's Pittsburgh corporate office.

Eckerd Health Services
620 Epsilon Drive
Pittsburgh, PA 15238

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Marie Pollock	Vice President	No
Brian Wyman	Manager	Yes
Richard Reese	Actuary	No

SCOPE OF AUDIT

The scope of audit services covered prescription drug benefit claims paid by EHS during the period from January 1, 2002 through December 31, 2003. Test work was performed on 220 previously processed claims, all of which were selected on a stratified, random (statistical) basis.

Scope elements included:

- Eligibility of claimants to receive payment.
- Calculation accuracy.
- Completeness of necessary information.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

II - STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 220 claims.

The claims were selected from the population of claims paid by EHS between January 1, 2002 and December 31, 2003. Prior to selection, the population of claims was stratified.

The strata types were as follows: (1) Top 20 highest dollar amount and, (2) Electronic or Mail Order (combined).

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on the plan's provisions in force as of the date the prescription was dispensed. Ingredient costs for electronic and paper (including out-of-network) claims were calculated based on Average Wholesale Prices (AWP) on the package size submitted or other applicable prices in effect on the date the prescription was dispensed. Ingredient costs for mail order claims were calculated based on AWP on package size submitted or other applicable prices in effect on the date the prescription was dispensed.

The percentage discounts, dispensing fees, and copayment amounts were compared to the plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan's requirements for:

- Exclusions,
- Pricing used at the time the prescription was dispensed,
- Recalculating payment amount,
- Appropriate copayment (generic, branded, etc.)
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations and,
- Eligibility of participant.

DEFINITION OF ERROR

All network pharmacy claim (electronic claims) payments were paid to the retail pharmacy. All mail order initial and refilled claim payments were paid to EHS mail order pharmacy.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

AUDIT RESULTS

Of the 220 claims in our statistical sample, 6 were judged to contain a payment error. This represents a frequency of payment error of 2.72%. Of these 6 claims, 2 were overpayments and 4 were underpayments.

Our sample contained a total payment of $147,725.11 for the 220 claims. The overpayments totaled $ 5.84 or .004% of the total. The underpayments totaled $30.46 or .02% of the total.

The sample's error magnitude, extended to the population, produces a projected overpayment of $30,056 (.069% of $43,488,648) and a projected underpayment of $156,765 (.36% of 43,488,648). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the sample strata.

As a result, we are 95 percent confident that the true value of the prescription paid claims during the period ranges from $ 44,659,085 (the $43,488,648 recorded claims, plus the $126,709 projected net error, plus the $ 1,043,728 value of the 2.4 percent precision) and $ 42,571,629 (the $43,488,648 recorded claims, plus the $ 126,709 projected net error, less the $1,043,728 value of the 2.4 percent precision).

The EHS standard accuracy rate is 99 percent or more of the gross dollar payments should be paid accurately. We understand the measurement is made by summing the overpayments and underpayments, and dividing the result by the total dollars and subtracting from 100%.

The overpayments/underpayments percentage from our results (extended to the population) total 0.02 percent. This equals a payment accuracy rate of 99.98 percent. These results are superior to the EHS standard accuracy rate. They are also superior to the 99% accuracy standard established by other claim processors with which we are familiar.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

EHS PHARMACY CLAIMS
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Did not use the correct MAC pricing.	3	$ 3.61
Did not use updated pricing to calculate ingredient cost.	2	(25.57)
Did not calculate copayment correctly	1	(2.66)
Total	6	$(24.62)

Corrective Action

EHS has included their response as **Exhibit B**. We attempted to contact EHS in order to review the 4 disputed errors (As indicated in EHS's response). However, EHS failed to respond to our calls. Therefore, those 4 claims remain as errors.

CONCLUSION

Based on our audit of 220 claims, we conclude EHS is processing the State and MUS claims in agreement with the plan provisions.

III - ELIGIBILITY

The State and MUS use various methods to report new entrants, changes and termination of coverage to EHS. This section describes the methods employed and presents the results of the verification of eligibility for 20 of the claims in our sample.

STATE OF MONTANA

The State prepares and sends to EHS a biweekly eligibility tape showing each individual to be covered for the coming month. EHS runs this tape and compares it to the data for the prior month. An exception report is generated showing all errors in the file. The exception report is sent back to the State for correction or approval to go ahead and load the file. If no exceptions were found, the file is loaded into the claim system.

MONTANA UNIVERSITY SYSTEM

Blue Cross Blue Shield of Montana (BCBSMT) processes claims for the MUS health care plan. BCBSMT has also contracted to provide eligibility data to EHS on behalf of MUS. BCBSMT receives the enrollment data from each campus on a daily basis and transmits new entrant, change and termination data to EHS electronically each day. An exception report is generated showing all errors in the file. The exception report is sent back to BCBSMT for correction or approval to go ahead and load the file. If no exceptions were found, the file is loaded into the claim system.

ELIGIBILITY VERIFICATION

Each of the 20 participants in our sample was researched on EHS eligibility system to verify that the participant's records indicated that coverage was in force on the date the prescription was dispensed.

No exceptions were noted.

Eligibility File Processing

During our review, EHS has informed us that the eligibility files are loaded on the same days that they are received from the State or BCBSMT. However, EHS stated that they cannot generate a system report for verification that the turnaround time for loading eligibility files are within two business days.

We reviewed the "Reformat Summary History" report for forty files noting the date received and the date loaded was within two business days.

Eligibility File Accuracy

During our review, EHS has informed us that there is no system report that can be generated to show uploading accuracy rate is at least 98%. EHS stated that if there are no exceptions found, the file is uploaded. For errors that were generated during uploading, they are sent back to the State or BCBSMT for corrections or approvals.

Identification Cards Timeliness

During our fieldwork at EHS office in Pittsburgh, we noted that EHS cannot generate a report showing an average turnaround time for identification cards within four business days for new or replacement cards. However, EHS stated that identification card data is sent to the outsource vendor on a nightly basis to be processed the following day.

CONCLUSION

We noted no exceptions were found during our review in the eligibility area. However, EHS could not provide information on uploading accuracy rate, generate a report showing all file loads were performed within two business days or verification that identification cards are processed within four business days. Not having this information, Wolcott & Associates, Inc. could not obtain assurance that the upload accuracy rate is at least 98%, that the eligibility file uploads are performed within two business days or that identification cards are generated within four business days.

IV - LOGIC AND CLAIM TEST RESULTS

This section presents the results of test claims submitted to the EHS claim system as a method of assessing the system's ability to identify inappropriate transactions.

LOGIC CLAIMS

We created a total of 10 fictitious electronic claims, working with a claim processor in the claim department in Pittsburgh. These claims were submitted to the system for processing. The electronic claims were submitted to the system in a test mode.

CLAIMS TESTED

We created a series of claims for the following situations:

- Two claims with same medication with different pharmacy,
- Two claims for medication inconsistent with the patient's gender,
- Two claims over age limit,
- Two claims over days supply limit and
- Two claims requiring prior authorization.

CONCLUSION

Based on our test results, we conclude that the EHS system is effective in identifying erroneous claims.

V - OTHER REVIEW ITEMS

Discussion regarding other claim review items are presented below.

PHARMACY NETWORK ACCESS

EHS agreed, based upon census, that 100% of covered participants living in suburban areas will have access to at least one network pharmacy within five miles of the participant and 96.4% of covered participants living in rural areas will have access to one network pharmacy within fifteen miles of the participant.

We reviewed reports generated by EHS stating that State participants had 100% access to one network pharmacy within a five mile radius in a suburban area and 99.1% had access to one network pharmacy within a fifteen mile radius in a rural area.

We reviewed reports generated by EHS stating that MUS participants had 100% access to one network pharmacy within a five mile radius in a suburban area and 98.9% had access to one network pharmacy within a fifteen mile radius in a rural area.

The EHS report made three assumptions when performing this analysis:

- The basis for the analysis was the zip code information received from the State and MUS.

- Percentages are based on all possible retail pharmacies (for the State all possible retail pharmacies met the access standard of one pharmacy within five miles for 99.8% of participants living in suburban areas and one pharmacy within fifteen miles for 89.8% of participants living in rural areas. For MUS all possible retail pharmacies met the access standard of one pharmacy within five miles for 98.8% of participants in suburban areas and one pharmacy within fifteen miles for 96% of participants living in rural areas.)

- Distance was measured using driving distance.

Conclusion

Based on the results of our review activity, we conclude that EHS is in compliance with the terms of the Association contract as it relates to the pharmacy network access.

PHARMACY AUDITING

EHS agreed to audit 10% of active network pharmacies each year of the contract. An active network pharmacy is defined as any pharmacy processing at least 400 prescriptions per year.

EHS has two field auditors performing approximately two on-site field audits per day. Procedural reviews with selected pharmacists are also performed during field audits. If errors are found, the pharmacy has 30 days for rebuttals.

We reviewed reports generated by EHS showing total finalized audits of only 2% of network pharmacies with over 400 prescriptions per year. EHS informed us that the Audit Department was not informed of the change in the final contract with the State and MUS. The Audit Department stated that the "caught up" audits were completed by August, 2004.

Recoveries

As of the date of this draft, EHS has not supplied us with information on amount of the audit recoveries.

Conclusion

Based on the results of our review activity, we conclude that EHS is not in compliance with the terms of the contract as it relates to the auditing of network pharmacies.

PHARMACY PARTICIPATION

EHS guaranteed that no more that 25% of the network pharmacies will voluntarily terminate their contracts with EHS during any calendar year.

EHS has informed us that they are unable to generate a report verifying that no more than 25% of the network pharmacies voluntarily terminated their contract with EHS. However, EHS has stated that they believe that no network pharmacies have terminated their contract.

Conclusion

Based on the results of our review activity, we are unable to conclude that EHS is in compliance with the terms of the contract as it relates to the pharmacy participation.

CUSTOMER SERVICE RESPONSE TIME

EHS guaranteed that a maximum telephone answering time averages less than 30 seconds for all customer service calls received. EHS also guaranteed an abandonment rate of less than 5% for all customer service calls.

EHS generated reports to verify the average speed to answer and the average abandonment rate for the State and MUS.

The report for the State shows an average speed to answer in 2002 was 18 seconds and in 2003 the average speed to answer was 65 seconds. The abandonment rate for the State in 2002 was 3.22% and in 2003 the abandonment rate was 7.04%. EHS informed us that they have paid 1% of their administrative fee for failure to meet the abandonment rate and average speed to answer in 2003.

The report for the MUS shows an average speed to answer in 2002 was 37 seconds and the abandonment rate in 2002 was 5.31%. EHS informed us that they paid 1% of their administrative fee for failure to meet the abandonment rate and average speed to answer in 2002.

EHS states that their failure to meet these guarantees was caused by new customer service technology being installed that caused the call center to be shut down for one week.

Conclusion

Based on the results of our review activity, we conclude that EHS is not in compliance with the terms of the contract as it relates to the customer service response time. However, we understand EHS has already paid the penalties associated with this guarantee.

REBATES

EHS agreed to rebates in an amount to a 90% pass through with a minimum guarantee of $2.00 per rebatable retail prescription claim and a minimum of $5.25 per rebatable mail order prescription claim of the market share rebate received by EHS.

EHS supplied us with copies of the "Flat Rate Disbursement Detail" showing all nonrebatable and rebatable prescriptions. EHS also supplied us with a copy of the corresponding check. We recalculated the invoices and traced the total dollar amount to the applicable checks without exceptions. However, we could not verify what drug was rebatable or which drug was not.

Starting in 2003, EHS included in their rebates for the State and MUS an escalator amount for additional reimbursement. The rebate escalator amount is calculated by comparing the weighted average per paid prescription (i.e. the discounted ingredient cost plus dispense fee before participant cost-share) from one year to the same weighted average calculated in the second year. The percentage increase in the weighted average is the escalator. However, we could not verify that the escalator was calculated correctly.

Conclusion

Based on the results of our review activity, we are unable to conclude that EHS is in compliance with the terms of the contract as it relates to rebates.

APPLICATION OF DEDUCTIBLE

Beginning 7/01/03 the State applied a $100.00 retail deductible, $250 per prescription out of pocket maximum and $1160 per participant yearly out of pocket maximum.

Of the 220 sample claims, we randomly selected 20 claims and examined the participant's history in EHS system to verify that EHS updated the State deductible and out of pocket maximums. In all 20 participants, we noted EHS had correctly entered the State's changes to the deductible and the participant out of pocket maximums.

EHS stated that retail claims are not suspended. When the pharmacist enters the claim into the system, the claim is either accepted or rejected (with a rejection code) at that time. A message is sent back to the pharmacist stating that the claim was accepted or rejected.

Conclusion

Based on the results of our review activity, we conclude that EHS has updated the changes to the State's deductible and out of pocket maximums and that retail claims are not suspended.

DENIAL CODES

EHS supplied us with reports showing the State and MUS claims that were rejected, the reason for the rejection and the pharmacy name. We sorted the reports to obtain the top 5 reasons for claim rejection. Our findings are presented below:

STATE - 2002

Reason	Number of Claims Rejected
Plan limitations exceeded	23,028
Refill too soon	10,750
DUR reject error	8,277
Prior authorization required	6,072
Non-matched cardholder ID	4,686

Total number of claims rejected for 2002 was 72,481.

Total number of claims rejected for filled after coverage has termed was 2,511.

STATE - 2003

Reason	Number of Claims Rejected
Plan limitations exceeded	14,272
Refill too soon	11,212
DUR reject error	9,928
Prior authorization required	4,741
Filled after coverage termed	4,025

Total number of claims rejected for 2003 was 60,152.

MUS - 2002

Reason	Number of Claims Rejected
Plan limitation exceeded	5,842
Non-matched cardholder ID	4,022
DUR reject error	4,006
Refill too soon	3,888
Product not covered	2,384

Total number of claims rejected in 2002 was 26,337.

Total number of claims rejected for filled after coverage termed was 1,580.

MUS - 2003

Reason	Number of Claims Rejected
Plan limitation exceeded	6,330
Non-matched cardholder ID	4,571
Refill too soon	4,540
DUR reject error	3,977
Product not covered	1,792

Total number of claims rejected in 2003 was 27,610.

Total number of claims rejected for filled after coverage termed was 1,564.

Conclusion

Based on the results of our review activity, we conclude that EHS rejection codes are reasonable and are effective in the claim system.

PRIOR AUTHORIZATION

At the State and MUS request, EHS has provide the ability to selectively approve certain drugs that would have to be preapproved by the physician prior to being filled at the pharmacy.

If a claim is entered into the claim system that requires a prior authorization, the claim is rejected and sent back to the pharmacist with the reason for the rejection. The pharmacist can call a toll free number to verify the rejection.

The physician may request a form to be faxed to their location to be completed by the physician. Once completed, the physician will fax back the prior authorization form. If the prior authorization is denied, the reason for the denial is faxed back to the physician. EHS informed us that only physicians can obtain prior authorization.

If a prior authorization is denied, EHS has an appeal process.

If the prior authorization is approved, the prior authorization number is entered into the system. After one year, the prior authorization number is expired.

EHS generated reports showing prior authorization denial rates and turnaround time for completed prior authorizations. Our findings are presented below:

State

Year	Denial Rate
2002	34.4%
2003	26.2%

MUS

Year	Denial Rate
2002	25.2%
2003	30.3%

The 220 claims in our sample were also reviewed to ensure that all prior authorization claims were properly identified and the prior authorization process was completed. No exceptions were noted.

EHS generated a report showing the average turnaround time for prior authorization cases. Between January 1, 2003 and December 31, 2003 the average turnaround time for prior authorization for the State was 5.96 days and 6.72 days for MUS. EHS did not track the turnaround time in 2002.

Conclusion

Based on the results of our review activity, we conclude that EHS prior authorization policies and procedures are being follow as prescribed.

MAIL ORDER PRESCRIPTION

EHS guaranteed that 95% of all mail service pharmacist approved prescriptions will be shipped within an average of 2 business days from the date of receipt. EHS guaranteed that 98% of all mail service pharmacist approved prescriptions requiring intervention will be shipped within an average of 5 business days from the date of receipt. EHS also guaranteed that electronic mail order claims will be processed with a 99% accuracy rate.

EHS generated reports to verify the turnaround time and processing accuracy rates. Our findings are presented below:

Performance Results for the State

Mail service processing time - non intervention:

Dates	Completion % in 2 days
1/01/02 to 12/31/03	100%

Mail service processing time - intervention:

Dates	100% order fulfillment in days
1/01/02 to 12/31/03	2.4 days

Dispensing Accuracy rate:

Dates	Accuracy rate percentage
1/01/02 to 12/31/03	99.999%

Performance Results for MUS

Mail service processing time - non intervention:

Dates	Completion % in 2 days
1/01/02 to 12/31/03	100%

Mail service processing time - intervention:

Dates	100% order fulfillment in days
1/01/02 to 12/31/03	1.7 days

Dispensing Accuracy rate:

Dates	Accuracy rate percentage
1/01/02 to 12/31/03	99.99%

Conclusion

Based on the results of our review activity, we conclude that EHS is in compliance with the terms of the contract as it relates to the mail order processing time and mail order accuracy rate.

Exhibit A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
PRESCRIPTION DRUG CLAIMS
CLAIMS PROCESSED FROM JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF FINDINGS

CLAIM #	CLAIM TYPE	DOS	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
129	retail	3/26/2002	$7.47	9.70	-2.23	Did not use correct MAC pricing.
140	retail	7/17/2002	5.47	3.74	1.73	Did not use correct MAC pricing.
141	retail	8/8/2002	5.24	1.13	4.11	Did not use correct MAC pricing.
114	retail	1/17/2002	14.02	16.57	-2.55	Did not use updated pricing.
30	retail	4/4/2002	192.88	215.90	-23.02	Did not use updated pricing.
204	retail	7/10/2003	0.00	2.66	-2.66	Incorrectly calculated copayment.
	Totals		$212.14	240.00	(22.39)	

Exhibit B

State of Montana and Montana University System Prescription Drug Audit

Wolcott & Associates Draft Review by John Hatala, PharamCare/EHS

Review: Exhibit A (PDF file)

These claims have been reviewed and here are our findings:
Claim number 129, 140, 141, and 204 all priced correct with no discrepancies on the EHS system. We would need more information to see where an error was identified.

Claim 114 the pricing was updated on 1/17/02 at the end of day 21:07:51. Claim paid prior to on 1/17/02. The effective date of the price AWP update was 01/04/02.

Claim 30 the pricing was added 4/11/02 claim paid on 4/4/02. The effective date of change was 4/1.

Response: No claim processing errors for the sample.

Review: Audit Report (PDF) pages I-2 to V-10

I Introduction –

Audit Timing and Staff – should be noted that the Wolcott auditor was offered direct access to the AS400 mainframe to review the claim sample; the offer to utilize the AS400 for review was declined.

Add EHS Participants –

Audit Coordinator - John Hatala, Regional Manager
Claims review - Theresa Sorg, Supervisor of Systems Administration; support staff was provided to research claims
Customer Service / Performance Statistics - Hal Brandt, Manager of Customer Service; Gina Tiani Supervisor Customer Service
Clinical Department / Prior Authorizations- Teddi Gianangeli, Pharm.D.,Senior Clinical Specialist
Eligibility Department / Processing & Accuracy -Robin Hileman, Supervisor of Eligibility Systems
Member Communications / ID Cards - Jamie Bostard, Supervisor of Member Communications

Network Department – Access & Pharmacy Audits - Nick Calla, RPh, Esq., Director of Clinical Programs and Network Administration; Heather Steele, Pharmacy Auditor
Finance / Rebates - Deidre Kramer, Senior Financial Analyst
Mail Service / Claim Review – Christina Pekich, Facility Manager

II Statistical Claim Audit Results

Audit Procedure – Correction; claims were not reprocessed. AS 400 mainframe screen prints were utilized to review claims.

Audit Results – No Payments Errors; section needs to be revised to reflect 100% accuracy of the sample reviewed.

Types of Errors – Modify to 100% accuracy; no corrective action required.

III Eligibility

Eligibility File Accuracy – Section should be modified to reflect that while a summary system report cannot be generated as Wolcott preferred, as stated on page IV –1 of the audit, "We (Wolcott) reviewed the "Reformatted Summary History" report for forty files noting the date received and the date loaded was within two business days." Similarly, regarding ID cards, data was provided to support that ID cards were issued within the required timeframe. But, only recent data was available not for the entire time period of the audit.

Conclusion – EHS disputes the conclusion. EHS' position is that information was provided during the audit that may not specifically match the reporting requested, but is satisfactory to demonstrate compliance with the contract for the Eligibility File Accuracy and ID Card provisions.

VI Logic and Claim Test Results

No changes.

VII Other Reviews

Pharmacy Auditing – The "catch-up" audits were made in good faith and have resulted in compliance with the contract. The State of Montana and MUS receive 100% of all audit recoveries and this information is available at the time the recovery is returned to the client.

Pharmacy Participation – EHS' position is that the guarantee is designed to assure network stability for our clients and in this regard we are compliant with the spirit of the contract.

Exhibit B (cont.)

Rebates – EHS disputes the conclusion. We discussed how a review of the "rebatable" drug data could be performed and Wolcott determined that this review was not practical given the time and resources allotted for this audit. EHS is compliant with the rebate terms of the contract. The rebate data provided to Wolcott was sufficient to validate that the escalator was calculated correctly. The escalator clause is a very complex calculation an EHS would welcome the opportunity to review this aspect of the contract to satisfy the auditor.

Exhibit C

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION
STATE OF MONTANA

Mitchell Building, Room 130
PO Box 200127
Helena Montana 59620-0127

(406) 444-3871
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http://discoveringmontana.com/doa/spd/css/

December 1, 2004

Marie Pollock, HIA
Vice President
Wolcott & Associates, Inc.
12120 State Line Road, Suite 297
Leawood, Kansas 66209

Subject: Prescription Drug Claim Audit for the Period January 1, 2002 through December 31, 2003

Dear Ms. Pollock:

We received your draft report on the State of Montana Prescription Drug Claim Audit for the period January 1, 2002 through December 31, 2003, and we provide the following responses to your audit findings and recommendations.

Contractual Compliance – Other Review Items

We have reviewed the conclusions listed by Wolcott & Associates, Inc. regarding EHS performance measures. The State of Montana has worked with EHS on a number of these performance measures and where appropriate assessed performance penalties as provided under the contract. With regard to the requirement for Pharmacy Auditing, we concur that EHS should conduct the required percentage of active network pharmacy audits. We anticipate these audits have the potential to result in claims cost recovery for the State Plan. In areas where Wolcott & Associates was unable to conclude that EHS is in compliance with the contract, the State will work with EHS to document performance and take any necessary steps to ensure compliance with the contract.

In general, we are pleased to see that the error rate for administering the pharmacy benefit plan is very low.

Thank you for providing us with the opportunity to respond to the recommendations.

Sincerely,

Connie Welsh

Connie Welsh, Chief
Employee Benefits Bureau

MONTANA UNIVERSITY SYSTEM
Office of the Commissioner of Higher Education

Exhibit D

2500 Broadway ◊ PO Box 203101 ◊ Helena, Montana 59620-3101 ◊ (406)444-6570 ◊ FAX (406)444-1469

December 2, 2004

Marie Pollock
Wolcott & Associates, Inc
12120 State Line Road, Suite 297
Leawood, Kansas 66209

RE: Claims Audit of EHS Pharmacy Benefit Management

Dear Ms Pollock:

Thank you for the opportunity to respond to your audit of the Montana University System pharmacy benefit plan administered by EHS. Overall your audit indicates that EHS is administrating our pharmacy benefit plan with a low error rate, although there are other service areas that are not in compliance with our contract.

The area with the most potential for claims cost recovery for the University System is provider audits that should be conducted by EHS. The Montana University System will ask EHS to comply with the contract and follow up to verify that any funds owed are collected and paid.

Thank you for the effort you and your staff put in on this audit.

Sincerely,

Glen D. Leavitt
Director of Benefits

STATE OF MONTANA,
MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF HMO CLAIMS PROCESSING FOR THE PERIOD JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

ADMINISTERED BY

NEW WEST HEALTH PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
PEAK HEALTH PLAN

FINAL REPORT

DECEMBER, 2004

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
HEALTH MAINTENANCE ORGANIZATION CLAIMS AUDIT
OF NEW WEST HEALTH PLAN, BLUE CROSS BLUE SHIELD OF MONTANA &
PEAK HEALTH PLAN
JANUARY 1, 2002 - DECEMBER 31, 2003

TABLE OF CONTENTS

I - INTRODUCTION

The State of Montana (State) provides self-funded HMO medical care benefit as part of an overall employee benefit and compensation program. The plan covers approximately 3,000 employees and retirees, plus their dependents.

The State has negotiated a contract with New West Health Plan (NWHP), Blue Cross Blue Shield of Montana (BCBSMT) and Peak Health Plan (PHP) to provide administration services to its plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and has also contracted to have their medical and dental care benefits administered by BCBSMT. The plan covers approximately 1,000 employees and retirees, plus their dependents.

The State invited MUS to participate in an audit of NWHP, BCBSMT and PHP's processing of medical care claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that we were awarded the audit contract on June 21, 2004. All preliminary work was completed and the entrance meeting was held in Helena on September 8, 2004. On-site work at the State, MUS, CHIP and BCBSMT was performed during the weeks of September 7 and 13, 2004.

On-site audit services were performed at:

State of Montana
State Personnel Division

Mitchell Building
Helena, Montana 59620

Montana University System
2500 Broadway
Helena, Montana 59620

New West Health Plan
40 West 14th Street, Suite 3
Helena, Montana 59601

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Peak Health Plan
2806 South Garfield Street
Missoula, Montana 59806

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Cathy McKittrick	Auditor	Yes
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care benefit claims paid by NWHP, BCBSMT and PHP during the period from January 1, 2002 through December 31, 2003. Test work was performed on 450 previously processed claims (150 claims per administrator), all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.

- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.
- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.
- Consistency of payments to member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

II - STATISTICAL CLAIM AUDIT RESULTS - NEW WEST HEALTH PLAN

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by BCBSMT between January 1, 2002 and December 31, 2003. Prior to selection, the population of claims was stratified.

NWHP converted from the Amisys system to the Diamond system in May, 2003. As of May, 2004, there was no access to the Amisys system. Therefore, our audit was performed on claims processed on the Diamond system. We reviewed the SAS 70 audit for the Amisys system, which was provided to us by NWHP.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on NWHP's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that NWHP is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).

- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 18 were judged to contain a payment error. This represents a frequency of payment error of 12.0%.

Our sample contained a total payment of $904,844.75 for the 150 claims. The overpayments totaled $9,271.95 or 1.02% of the total. The underpayments totaled $2,067.32 or 0.23% of the total. This financial error rate is less favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also less favorable than the NWHP standard of 1%.

The frequency of payment error in our sample is less favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also less favorable than the NWHP standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 6.6%, that the true frequency of error in the population is within the range of 5.4% to 18.6%.

Based on this extension, we believe that the true magnitude of payment error in the population is $107,076 or (2.8% of payments in the population). The magnitude of payment error is the sum of $82,245 in projected overpayments plus $24,831 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

A summary of error by type is presented below:

NWHP HEALTH CARE CLAIMS
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of co-insurance and/or deductible .	8	$ 4,447.09 net
Incorrect application of copay provisions.	6	12.50 net
Duplicate payment.	1	121.68
Incorrect repricing.	2	(266.24) net
Payment of unlisted procedure.	1	2,889.60
Total	18	$7,204.63

NWHP has included their response as **Exhibit D**.

RECOMMENDATIONS

Our recommendations are as follows:

- We believe NWHP identify the magnitude of overpayment caused by the configuration issues regarding deductible and coinsurance application. We further recommend that NWHP reimburse the State and MUS the amount of the overpayments identified.

- We recommend that NWHP conduct further training in the repricing of claims that contain multiple procedures.

- We understand that NWHP is currently working towards formalizing their internal audit process, in order to identify areas in need of further training and/or configuration modifications.

- We further understand that NWHP has instituted a manual review of all claims for the State and MUS. They have audited this process and have reported to us that the results are 98% procedural accuracy and 99.9% financial accuracy.

- We understand that the State and MUS have formalized a plan document as of September, 2004. We believe NWHP should make the appropriate changes to the claim processing system to reflect the provisions of the formalized plan.

- We understand that NWHP plans on continuing the audit process utilizing the services of Wolcott & Associates, Inc., and share the results of this audit process with the State and MUS. NWHP is also accepting responsibility regarding payment of these services.

III - STATISTICAL CLAIM AUDIT RESULTS - BCBSMT

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by BCBSMT between January 1, 2002 and December 31, 2003. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 16 were judged to contain a payment error. This represents a frequency of payment error of 10.7%.

Our sample contained a total payment of $562,599.40 for the 150 claims. The overpayments totaled $6,139.21 or 1.09% of the total. The underpayments totaled $1,192.80 or 0.20% of the total. This error rate is less favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 1%.

The frequency of payment error in our sample is less favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 1.4%, that the true frequency of error in the population is within the range of 9.3% to 12.1%.

Based on this extension, we believe that the true magnitude of payment error in the population is $47,210 or (8.4% of payments in the population). The magnitude of payment error is the sum of $34,477 in projected overpayments plus $12,733 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of co-insurance and/or deductible .	12	$ 4,328.17 net
Incorrect application of copay provisions.	1	(34.24)
Incorrect application of out-of-network benefits.	2	917.08 net
Incorrect repricing.	1	(264.60)
Total	18	$4,918.51

BCBSMT has included their response as **Exhibit E**.

RECOMMENDATIONS

Our recommendations are as follows:

- We believe the audit results are less than favorable and are due to several coding issues. We believe BCBSMT should reimburse the State and MUS the overpayments in the population as a result of the coding issues.

- We understand that the State and MUS have formalized a plan document as of September, 2004. We believe BCBSMT should make the appropriate changes to the claim processing system to reflect the provisions of the formalized plan.

- We further recommend that the plan be audited during 2005, in order to verify that the provisions of the plan are being processed appropriately. We recommend that BCBSMT reimburse the State and MUS for the performance of the follow-up audit.

IV - STATISTICAL CLAIM AUDIT RESULTS - PEAK HEALTH PLAN

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by PHP between January 1, 2002 and December 31, 2003. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on PHP's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that PHP is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 7 were judged to contain a payment error. This represents a frequency of payment error of 4.7%.

Our sample contained a total payment of $286,286.54 for the 150 claims. The overpayments totaled $283.60 or 0.10% of the total. The underpayments totaled $406.26 or 0.14% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the PHP standard of 1%.

The frequency of payment error in our sample is within the three to five percent error rate normally observed during our audits of similar plans. It is less favorable than the PHP standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 3.9%, that the true frequency of error in the population is within the range of 0.8% to 8.6%.

Based on this extension, we believe that the true magnitude of payment error in the population is $4,754 or (0.64% of payments in the population). The magnitude of payment error is the sum of $1,549 in projected overpayments plus $3,205 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit C**. A discussion of error types is presented below.

A summary of error by type is presented below:

PHP HEALTH CARE CLAIMS
JANUARY 1, 2002 THROUGH DECEMBER 31, 2003
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of co-insurance and/or deductible.	3	$ (122.89) net
Incorrect application of copay provisions.	3	(154.97)
Incorrect application of out-of-network benefits.	1	155.20
Total	7	$(122.66)

PHP has included their response as **Exhibit F**.

RECOMMENDATIONS

Our recommendation is as follows:

- We believe the results to be more favorable than the other vendors. However, the frequency of error is still less favorable than industry standard. Therefore, since the State and MUS have formalized a plan document, we believe PHP should be included in any follow-up audit activity for the HMO plan. We fuerther recommend that PHP reimburse the State and MUS for the performance of the follow-up audit.

V - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT. This section describes the methods employed and presents the results of the verification of eligibility for the 450 (150 claims per administrator) in our sample where a payment was made by each administrator.

STATE OF MONTANA

The State prepares and sends to the NWHP and BCBSMT a biweekly eligibility tape showing each individual to be covered for the coming month. The administrators run this tape and compares it to the data for the prior month.

PHP receives an excel file showing eligibility changes. They then enter the new eligibility changes in the system manually.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

The administrator's receive the enrollment data from each campus on a daily basis. NWHP, BCBSMT and PHP then follow the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the administrator's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

VI - ID CARD ISSUANCE

Upon entry of the new eligibility information in each of the administrator's systems, an ID card is automatically generated. The procedures are the same in each of the three administrators.

ID cards are issued the following day after an entry warrants the issuance of the card at BCBSMT and PHP. NWHP only prints ID cards once a week, unless a request for a more immediate turnaround time is received from the plan sponsor.

We believe the ID card issuance procedures at each of the administrator's is consistent with procedures at other insurance companies and third party administrator's with which we are familiar. The only exception is the the procedure at NWHP may cause some delay with only printing ID cards once a week.

VII - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 450 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the date the claim was processed.

Results, by plan sponsor, are presented below.

NWHP

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	32
Median	15
Mode	1

NWHP informed us that company policy for turnaround time is 14 day.

BCBSMT

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	6
Median	3.5
Mode	1

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

PHP

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	26
Median	23
Mode	23

PHP informed us that company policy for turnaround time is 14 days.

COMMENT

The turnaround time results for NWHP and PHP do no meet their own turnaround time standards and do not meet industry standards. BCBSMT do meet their own turnaround time standard and industry standards.

VIII - OTHER REVIEW AREAS

The results of our review in areas requested by the three plan sponsors is as follows.

SUSPENDED CLAIMS

We requested reports from all the administrators. NWHP is the only administrator that provided the report to Wolcott & Associates, Inc. regarding the percentage of claims submitted that were suspended, reasons for suspension, and the average length of time before these claims were paid or denied.

BCBSMT did not provide the requested information for any of the three plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

PHP indicated that their system could not provide this type of report.

Results - NWHP

NWHP reported that for the State, 8,077 claim lines were suspended for an average length of time of 22 days. The top five reasons for suspension are as follows:

- Pre-existing investigation,
- Possible duplicate claim,
- CM hold claims to be released, and
- Office surgery, pay under office visit co-pay until 1/1/04,
- Mammogram, verify benefits.

NWHP reported that for MUS, 5,162 claim lines were suspended for an average length of time of 25 days. The top five reasons for suspension are as follows:

- Pre-existing investigation,
- Group Accumulator,
- Possible duplicate claim,
- Multiple authorizations, and
- Mammogram, verify benefits.

DENIED CLAIMS

We requested reports from all the administrators. NWHP and PHP were the only administrators that provided the reports regarding the number of claims denied, including provider type, amount and if there were multiple denied claims for one provider. In addition, determine the percentage denied due to ineligibility of a member.

BCBSMT did not provide the requested information for any of the three plan sponsors. They indicated to us that this is not a report typically provided to plan sponsors.

Results - NWHP

NWHP reported that 3,035 claim lines (State and MUS combined) were denied.

NWHP reported that the top 5 reasons for denial were as follows:

- Duplicate claim submission,
- Authorization required for service,
- Not covered benefit,
- Member not eligible for date of service, and
- Remit claim to MHNet.

The total amount for denied claims was $898,385.27.

Multiple claims were denied several different providers, including all provider types. There were no patterns for denial for any particular provider and/or type.

We calculated that 3.3% of all the denials were for member not eligible for benefits.

We calculated that 26.4% of all the denials were due to lack of preauthorization for services.

Results - PHP

PHP did not provide a count total for denied claims.

PHP reported that the top 5 reasons for denial were as follows:

- Duplicate claim submission,
- Plan limits for routine services,
- Not covered benefit - dental,
- Charges prior to and/or after effective date, and
- Pre-existing condition.

The total amount for denied claims (State and MUS) was $166,545.71.

PHP did not include providers and provider type in their report.

We calculated that 108 claims were denied for member not eligible for benefits.

We noted that no claims were denied due to lack of preauthorization for services.

Comment

PHP indicated to us that the State does not require preauthorization for services.

We believe this may be in conflict with the State's plan provisions.

PREAUTHORIZATION

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. BCBSMT and NWHP utilize resources internally. PHP utilizes the services of Rocky Mountain Health Network for the preauthorization process. The procedure can be initiated by either the individual or the provider of services. The services requiring preauthorization are typical with other plans with which we are familiar.

EXHIBIT A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT - NEW WEST HEALTH PLAN
SUMMARY OF FINDINGS
AUDIT PERIOD JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

Claim No.	Group	Amount Paid	Audited Amount	Dollar Value of Error	Type
351892a	University	15,938.62	16,594.01	(655.39)	The co-ins. should not have been applied. Out-of-pocket was already met.
49847a	University	314.00	299.00	15.00	Should have applied Co-pay for well-child visit.
305301	State	2,520.00	1,890.00	630.00	Should have applied co-insurance for this DME. Out-of-pocket maximum does not apply to DME.
65703	University	2,793.69	2,343.19	450.50	Should have applied co-insurance to all lines. Out-of-pocket had not been met.
147159	University	21.75	31.75	(10.00)	Applied a $25 urgent care co-pay to charges that were indicated performed in a provider's office, rather than an urgent care facility.
308232	University	313.45	241.68	71.77	Should have applied remaining deductible amount to this claim.
160910a	University	313.77	192.09	121.68	Charges for one of the dates of service should have been denied as duplicates. Error occurred during adjustment.
116418	State	313.91	237.18	76.73	Should have applied co-insurance to this claim.
142142	State	314.75	212.25	102.50	Should have applied $15 co-pay for office visit and applied co-insurance for remaining charges.
e282389	State	17,869.90	16,167.68	1,702.22	Should have applied co-insurance to this claim.
191968	University	2,889.60	-	2,889.60	Should not have paid an unlisted procedure without requesting

					further information regarding services performed.
302681	University	2,996.89	3,071.89	(75.00)	Applied two ER co-pays incorrectly.
e290833	State	2,600.63	300.63	2,300.00	Should have applied deductible and co-insurance to this claim.
e103870	State	2,555.72	3,733.91	(1,178.19)	Incorrect repricing for member hospital.
e123029	State	39.98	49.98	(10.00)	Applied a $25 urgent care co-pay to charges that were indicated performed in a provider's office, rather than an urgent care facility.
e110077	University	39.98	49.98	(10.00)	Applied a $25 urgent care co-pay to charges that were indicated performed in a provider's office, rather than an urgent care facility.
130894	State	2,663.26	2,792.00	(128.74)	Applied co-insurance to claim. Co-insurance was already met.
485276	State	2,725.47	1,813.52	911.95	Incorrectly repriced multiple surgery claim.
Totals		57,225.37	50,020.74	7,204.63	

EXHIBIT B

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - BCBSMT
AUDIT PERIOD JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
42309826350	University	1,925.98	2,804.94	(878.96)	Claim should have been paid at non-network. Coding error.
13031100160	State	1,926.43	1,701.43	225.00	Should have applied charges to deductible.
13020329830	State	1,721.11	1,288.00	433.11	Claim processed incorrectly due to coding error. Should have applied charges to deductible.
12284314700	State	1,688.33	1,952.93	(264.60)	Claim for multiple procedures was priced incorrectly.
13177100060	State	1,824.47	1,748.21	76.26	Should have applied co-ins to inpatient inhalation therapy during inpatient stay.
13227307810	State	1,808.37	1,367.53	440.84	Should have applied co-ins. to maternity claim.
13211336290	State	1,679.28	1,270.71	408.57	Should have applied co-ins. to maternity claim.
13083300370	University	1,884.12	1,367.53	516.59	Should have applied co-ins. to maternity claim.
12169320810	State	1,732.16	1,747.16	(15.00)	Should have applied co-ins. to maternity claim.
13125100130	University	13,550.25	11,583.11	1,967.14	Should have applied charges to co-ins. Coding error.
03308004100	State	11,110.29	11,025.88	84.41	Should have applied charges to co-ins. Coding error.
03290004010	State	15,844.93	14,048.89	1,796.04	Should have applied Out-of-network benefits.
13049112950	State	171.98	206.22	(34.24)	Should have only applied a $75 copay for ER charges.
42247804300	University	150.00	-	150.00	Charges should have applied to

					deductible.
03345259040	State	204.93	191.58	13.35	Claim should have applied remaining co-ins.
13219108120	State	1,889.00	1,861.10	27.90	Claim should have applied remaining co-ins.
	Totals	57,222.63	52,304.12	4,918.51	

EXHIBIT C

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - PEAK HEALTH PLAN
AUDIT PERIOD JANUARY 1, 2002 THROUGH DECEMBER 31, 2003

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
200306051488	STATE	12,743.66	12,818.66	(75.00)	Should not have applied $75 ER co-pay to inpatient stay.
200301070446	UNIVERSITY	8.40	-	8.40	Should have applied charges to deductible. Services not performed in provider's office.
200311106536	STATE	1,024.73	904.73	120.00	Should have applied $15 occupational therapy co-pay per visit.
200301231560	STATE	1,163.99	1,008.79	155.20	Non-network VA hospital claim paid at network level benefits.
200209050141	UNIVERSITY	197.59	397.56	(199.97)	Claim for ER visit should have paid with $75 co-pay then remaining charges at 100%
200307210273	STATE	1,099.71	1,404.46	(304.75)	Claim for ER visit should have paid with $75 co-pay then remaining charges at 100%
200306303879	STATE	3,253.07	3,358.13	(105.06)	Applied incorrect benefit level to one line of inpatient stay.
200301071718	UNIVERSITY	1,046.13	1,072.36	(26.23)	Applied deductible after it had already been satisfied.
	Totals	20,537.28	20,964.69	(427.41)	

NEW WEST
HEALTH SERVICES

New West Health Plan-A Division of New West Health Services

Exhibit D

December 1, 2004

Marie Pollock
Wolcott & Associates, Inc.
12120 State Line Road, Suite 297
Leawood, Kansas 66209

Re: Audit of State of Montana & Montana University System

Dear Ms. Pollock:

We have reviewed the results of your audit of New West Health Services' claims processing for the State of Montana and U-System members for calendar years 2002 and 2003, with the notation that, due to a system conversion, the audit sample was limited to claims from the post conversion period only (5/1/03 to 12/31/03).

The audit results indicate an error rate that is outside New West's normal operating parameters and standard industry norms. Our review and research have pinpointed the primary causative factors and we have taken substantive measures to correct the problems. We accept the serious nature of this matter and pledge our full commitment toward a complete and satisfactory resolution.

The following summary comments detail our analysis of the primary causative factors:

- New West was challenged by a simultaneous claims system conversion and the assimilation of a troubled insurer, Montana Benefits and Life Company (MBLC);
- New West historically outsourced its IT System including claims processing, enrollment and premium billing until 5/1/03 when, in order to satisfy Federal/State HIPAA/DOL requirements, we internalized these processes on a new system;
- This formidable project included the simultaneous conversion of the former MBLC IT system and establishment of a Kalispell based operations/customer service center;
- In-sourcing these operational functions in addition to the complex system configuration, benefit set up, training and incorporation of former MBLC staff and newly hired staff clearly resulted in compromised operations for a period of time; and
- Another significant challenge, after thorough review, has been the realization of the unclear components of the State and U-System Summary Plan Description (SPD), which led to misunderstandings of benefit interpretation and adjudication protocols.

Subsequent corrective action plans:

- New West removed the Director of Operations and Director of IT during the fall of 2003 and winter of 2004 and utilized a national firm to provide interim management and system consulting services to accurately diagnose and establish corrective action plans for all noted problems;
- Starting in the second (2nd) quarter of 2004, and ending in the fourth (4^{th}) quarter of 2004, New West successfully recruited a new operations management team with an average of 20+ years experience in the health insurance industry;
- This operations management team represents a diverse level of skill, talent and experience from several national markets. These positions include a Director of Operations, Director of IT, Claims Manager, Configuration Manager and an Oracle Database Administrator;
- New West created an Internal Auditor position, reporting directly to the Chief Executive Officer and the Board of Directors;
- New West created a Quality Control position within the Claims Department to lead a new continuous quality improvement process which includes routine claims audits, identification and trending of processor errors and follow up training activities;
- New West hired Wolcott & Associates to conduct a series of ongoing quarterly audits, with focused feedback on problem identification and process/protocol improvement. These voluntary audits, at New West's expense, will continue until both the State of Montana/U-System and New West are satisfied that our claims processing performance has returned to standard industry normative levels;
- In order to ensure an acceptable level of performance during the completion of the corrective action activities, New West instituted a manual review of all State/U-System claims in October 2004. Our initial audit of this manual review protocol revealed a procedural accuracy level of 98% with a financial accuracy of 99.9%;
- New West staff has worked diligently with the State of Montana and U-System benefit staff to clarify and improve SPD language and protocols. New West has created new internal procedures to help staff recognize the unique characteristics of the State and U-System benefit plan and operating protocols;
- New West has retained a nationally experienced IT consulting firm to audit the State of Montana/U-System's unique benefit plan configuration to ensure the quick return to an accurate and timely automated claims process; and
- New West routinely reconciles (monthly/quarterly) all issues that can periodically result in claims over or under payments and makes adjustments to affected providers, employers and members. New West will continue this standard practice and maintain our compliance with the State of Montana/U-System contract terms.

In conclusion, New West will conduct an exhaustive effort and expend all required resources to ensure the immediate return to a high quality standard of performance. We will continue to work, in a collaborative and forthright manner, with State of Montana/U-System benefit personnel and auditors to regain your complete confidence.

Sincerely,

James D. Senterfitt
Chief Operating Officer

ALLEGIANCE
BENEFIT PLAN MANAGEMENT, INC.

Exhibit E

RESPONSE TO PEAK/MONTANA UNIVERSITY SYSTEM AUDIT ERROR LIST

This Memorandum should serve as Allegiance Benefit Plan Management's response to the audit error list produced from the Peak/Montana University system audit for the period January, 2002 through December 31, 2003.

After review of the audit results, Allegiance disagrees with the audit findings regarding several of the claims identified by the auditor as claims payment errors. Those claims so identified are listed by claim number and addressed as follows:

Claim #200305164702. The auditor states that a $15.00 occupational therapy copay should have been applied per visit for these claims. Allegiance disagrees. These claims were treated as partial hospitalization claims wherein under the terms of the Plan, two days partial hospitalization equal one day of inpatient hospitalization. Therefore, the claims are treated as inpatient treatment. All occupational therapy was conducted during the partial hospitalization stays. Therefore, since these are treated as inpatient claims, the outpatient occupational therapy should not apply, and the $15.00 copay is therefore inapplicable. These were mental nervous claims paid under the mental nervous benefit.

Claim #200301231560. The auditor indicates that Veteran's Administration hospital claims should be paid as non-network. Though technically this is correct, by applying the in-network benefit to the VA charges, both the Plan and the patient realize a savings. The charges paid by the plan are much less than if the insured went to a non-PPO provider. We do not want to discourage them from seeking services at a VA facility at reduced charges.

Claim #200308040976. The auditor indicates that the claims for pre-existing conditions, and the pre-existing condition $5,000 limited benefit had been met. Therefore, the claims in excess of the $5,000 pre-existing benefit should have been denied. Allegiance disagrees. The pre-existing condition was a mental-nervous condition. A review of the EOBs and claims submitted indicate that those claims coded with mental-nervous codes were, in fact, applied to the pre-existing condition benefit. However, a number of the treatments for this emergency admission were of a more general nature, testing for drugs and other physical health problems that by diagnosis do not appear related to the pre-existing diagnosis. Therefore, under the HIPAA definition of pre-existing condition, the pre-existing condition limitation could not be applied to these charges.

Claim #200209050141, #200307210273. Under these claims, the auditor has indicated that the claims for the emergency room visit should have been paid subject to a $75.00 copay, and then all remaining charges paid at 100%. However, the Plan clearly states that copays, such as the $75.00 emergency room copay, apply only to facility services. In addition, we have received clarification to that effect from the Peak Plan individuals (the Paradigm Group, in which they indicate that all other services, such as physician services and the like, are subject to the deductible and then 25% co-insurance). Therefore, for the two claims in question, the $75.00 emergency room copayment was applied correctly to the facility charge and the remaining charges were applied to the deductible and then paid with 25% co-insurance. They then changed this to all charges subject to a $75.00 copay.

Claim #200303100817. The auditor states that charges should have been applied to coinsurance, rather than to a copayment, because the services were not provided in provider's office. That is based upon the auditor's reading of "place of service 22" code. However, from direction received by Glenn Leavitt, Director of Benefits, Montana University System, on September 19, 2003, this claim was for a routine mammogram, and Allegiance was directed that such routine care was not subject to coinsurance, but was in fact subject only to a $15.00 copay. Therefore, the claim was processed correctly. They then changed it to no deductible and no co-payment. They were supposed to notify us of any claims processed with a $15.00 copay on a case-by-case basis so that we could reprocess with the new guidelines. This claim was not brought to our attention: mammograms are never done in a physician's office so would always be coded POS22.

BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross and Blue Shield Association

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Helena, Montana 59
(406) 444-8200
Customer Informati
1-800-447-7828
Website:
www.bluecrossmonti

13020

November 30, 2004

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Managed Care Claim Audit

12284

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University Syste and State of Montana Managed Care claim audit recently completed for the audit peri January 1, 2002 through December 31, 2003.

13177

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings in Exhibit B, and Recommendations.

Exhibit B

Claim	
42309826350	"Claim should have been paid at non-network. Coding error." claim is underpaid $878.96 (MUS) **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay applicatior in and out of network providers. This coding error was origina discovered by BCBSMT and discussed with MUS. Claims wei not adjusted per the group's directive.
13031100160	"Should have applied charges to deductible." The claim is overpaid $225.00 (State) **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay applicatio in and out of network providers. This coding error was origina discovered by BCBSMT and discussed with the State. Claims were not adjusted per the group's directive.

13227

13211

Comment: BCBSMT agrees with this finding. This coding error was originally discovered by BCBSMT and discussed with the State. System coding was corrected 10/06/04 for deductible/copay application on maternity professional services. Claims were not adjusted per the group's directive.

13083300370 "Should have applied co-ins. to maternity claim." This claim is overpaid $516.59 (MUS)

Comment: BCBSMT agrees with this finding. This coding error was originally discovered by BCBSMT and discussed with MUS. System coding was corrected 10/06/04 for deductible/copay application on maternity professional services. Claims were not adjusted per the group's directive.

12169320810 "Should have applied co-ins. to maternity claim." Auditor's statement should read, "Should **not** have applied co-ins. to maternity claim." This claim is underpaid $15.00 (State)

Comment: BCBSMT agrees with this finding. This coding error was originally discovered by BCBSMT and discussed with the State. System coding was corrected 10/06/04 for deductible/copay application on maternity professional services. Claims were not adjusted per the group's directive.

13125100130 "Should have applied charges to co-ins. Coding error." The claim is overpaid $1967.14 (MUS)

Comment: BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay application on in and out of network providers. This coding error was originally discovered by BCBSMT and discussed with MUS. Claims were not adjusted per the group's directive.

03308004100 "Should have applied charges to co-ins. Coding error." The claim is overpaid $84.41 (State)

Comment: BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay application on in and out of network providers. This coding error was originally discovered by BCBSMT and discussed with State. Claims were not adjusted per the group's directive.

03290004010	"Should have applied Out-of-network benefits." The claim is overpaid $1796.04 (State) **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay application on in and out of network providers. This coding error was originally discovered by BCBSMT and discussed with State. Claims were not adjusted per the group's directive.
13049112950	"Should have only applied a $75 copay for ER charges." This claim is underpaid $34.24 (State) **Comment:** BCBSMT agrees with this finding. This issue was due to incorrect coding under the Urgent/Emergency benefit. Deductible and copay were not being applied correctly. The system coding was corrected 10/06/04 but no claims were adjusted, per the State's directive.
42247804300	"Charges should have applied to deductible." The claim is overpaid $150.00 (MUS) **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay application on in and out of network providers. This coding error was originally discovered by BCBSMT and discussed with MUS. Claims were not adjusted per the group's directive.
03345259040	"Claim should have applied remaining co-ins." The claim is overpaid $13.35 (State) **Comment:** BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay application on in and out of network providers. This coding error was originally discovered by BCBSMT and discussed with State. Claims were not adjusted per the group's directive.
13219108120	"Claim should have applied remaining co-ins." The claim is overpaid $27.90 (State)

Comment: BCBSMT agrees with this finding. The system coding was corrected 10/06/04 for deductible/copay application on in and out of network providers. This coding error was originally discovered by BCBSMT and discussed with State. Claims were not adjusted per the group's directive.

III-3 RECOMMENDATIONS

- "We believe the audit results are less than favorable and are due to several coding issues. We believe BCBSMT should reimburse the State and MUS the overpayments in the population as a result of the coding issues."

Comment: As noted in the comments for Exhibit B, BCBSMT identified the coding errors and discussed them with the groups. No adjustments were made at the groups' directive, so there is no reimbursement to the groups applicable for the system coding errors.

- "We understand that the State and MUS have formalized a plan document as of September 2004. We believe BCBSMT should make the appropriate changes to the claim processing system to reflect the provisions of the formalized plan."

Comment: As noted in the comments for Exhibit B, BCBSMT has already corrected the system coding to reflect language in the formalized plan document for the State of Montana. The University System has no formalized plan document, however the coding changes made during the audit should make the application of benefits consistent with the State plan document.

- "We further recommend that the plan be audited during 2005, in order to verify that the provisions of the plan are being processed appropriately. We recommend that BCBSMT reimburse the State and MUS for the performance of the follow-up audit."

Comment: There were three basic coding issues noted during the audit. The coding issues were deductible/co-payments for in and out of network providers, co-insurance for maternity claims, and claims processing under the urgent/emergency benefit. Besides the fact that there is no language in the contract with the State or MUS to support this recommendation, we have resolved the coding errors and do not believe that the issues are of significant volume or magnitude to warrant another audit.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

Exhibit G

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION
STATE OF MONTANA

Mitchell Building, Room 130
PO Box 200127
Helena Montana 59620-0127

(406) 444-3871
FAX: (406) 444-0703
http://discoveringmontana.com/doa/spd/css/

December 1, 2004

Marie Pollock, HIA
Vice President
Wolcott & Associates, Inc.
12120 State Line Road, Suite 297
Leawood, Kansas 66209

Subject: Analysis and Evaluation of HMO Claims Processing
for the Period January 1, 2002 through December 31, 2003

Dear Ms. Pollock:

We received your draft report on the State of Montana Analysis and Evaluation of HMO Claims Processing for the period January 1, 2002 through December 31, 2003, and we provide the following responses to your audit findings and recommendations.

New West Health Plan
We concur with the recommendations listed by Wolcott & Associates, Inc. regarding NWHP adjudication of State of Montana HMO plan claims. Prior to the audit we began working with NWHP to identify and correct a number of these issues, and NWHP has been responsive in addressing these issues. The State will continue to work with NWHP to resolve these issues on a prospective basis as well as correcting prior claims errors.

Blue Cross and Blue Shield of Montana
We concur with the recommendations listed by Wolcott & Associates, Inc. regarding BCBSMT adjudication of State of Montana HMO plan claims. As outlined in your audit findings, the State has formalized a plan document for use in correcting coding issues. The State will continue to work with BCBSMT to resolve the outstanding issues on a prospective basis as well as correcting prior claims errors.

Peak Health Plan
We concur with the recommendations listed by Wolcott & Associates, Inc. regarding PHP adjudication of State of Montana HMO plan claims. The State is working on formalizing a

plan document for use by PHP to assist in correcting coding issues. Currently the State has observed a lower level of errors in the PHP which we believe will be further reduced and meet industry standards once the plan document is available.

Thank you for providing us with the opportunity to respond to the recommendations.

Sincerely,

Connie Welsh

Connie Welsh, Chief
Employee Benefits Bureau

Exhibit H

MONTANA UNIVERSITY SYSTEM
Office of the Commissioner of Higher Education

2500 Broadway ◊ PO Box 203101 ◊ Helena, Montana 59620-3101 ◊ (406)444-6570 ◊ FAX (406)444-1469

December 2, 2004

Marie Pollock
Wolcott & Associates, Inc
12120 State Line Road, Suite 297
Leawood, Kansas 66209

RE: Audit of HMO Claims Payment

Dear Ms Pollock:

Thank you for the opportunity to respond to your audit of the Montana University System employee group HMO insurance plans as administered by New West Health Plan, Blue Cross Blue Shield of Montana, and Peak Health Plan. Overall, your audit indicates that New West Health Plan and BCBSMT's claims processing error rates do not meet industry standards while Peak Health Plan's error rates do, although Peak could do better. You also indicate that New West and Peak do not meet industry standards for claims turn around time. While your recommendations do not require specific Montana University System follow-up, you do recommend that follow up audits be conducted in the next calendar year to monitor the progress in the correction of error rates. The University System concurs with this recommendation and will request that the third party administrators comply with your recommendation.

Thank you for the effort you and your staff put in on this audit.

Sincerely,

Glen D. Leavitt
Director of Benefits